AFTER INJURY, THE BATTLE BEGINS: EVALUATING WORKERS' COMPENSATION FOR CIVILIAN CONTRACTORS IN WAR ZONES

HEARING

BEFORE THE

SUBCOMMITTEE ON DOMESTIC POLICY

OF THE

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

ONE HUNDRED ELEVENTH CONGRESS

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AFTER INJURY, THE BATTLE BEGINS: EVALUATING WORKERS' COMPENSATION FOR CIVILIAN CONTRACTORS IN WAR ZONES

THURSDAY, JUNE 18, 2009

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON DOMESTIC POLICY,
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM,
Washington, DC.

The subcommittee met, pursuant to notice, at 6:45 p.m., in room 2154, Rayburn House Office Building, Hon. Dennis J. Kucinich (chairman of the subcommittee) presiding.

Present: Representatives Kucinich, Cummings, Watson, and Jordan.

Also present: Senator Sanders.

Staff present: Jaron R. Bourke, staff director; Claire Coleman, counsel; Jean Gosa, clerk; Charisma Williams, staff assistant; Ron Stroman, chief of staff, full committee; Carla Hultberg, chief clerk, full committee; Jenny Thalheimer Rosenberg, press secretary, full committee; Adam Hodge, deputy press secretary, full committee; Jennifer Safavian, minority chief counsel for oversight and investigations; Dan Blankenburg, minority director of outreach and senior adviser; Adam Fromm, minority chief clerk and Member liaison; and Ashley Callen, minority counsel.

Mr. KUCINICH. The committee will come to order. First of all, I want to begin by thanking all the witnesses for their patience. We have had possibly an historic number of votes today, consecutively. We have been voting pretty much for the better part of 8½ hours. When there is a vote on in the House, it takes precedence over committee meetings.

As important as this committee meeting is, we wanted to come back here to continue and not to ask you to try to make arrangements when many of you have already traveled a great distance. I have talked to many Members and since every Member has had a great deal of difficulty in their own schedules, we will have some Members who are going to be coming in and out.

But in the interests of proceeding efficiently and getting to the witnesses, I am going to ask those Members who are here to limit their opening remarks, if they have any, to 2½ minutes. So without objection, opening remarks will be limited to 2½ minutes.

Without objection, we will be joined by Senator Sanders. Welcome Senator.

This is the Domestic Policy Subcommittee of Oversight and Government Reform. I am Dennis Kucinich, chairman of the commit-

tee. The title of today's hearing is, "After Injury, the Battle Begins: Evaluating Workers' Compensation for Civilian Contractors in War Zones."

This hearing will evaluate workers' compensation insurance for Federal contractors working overseas under the Defense Base Act, a little known law passed in 1941 requiring all U.S. Government contractors and subcontractors to secure workers' compensation insurance for their employees.

Today's hearing focuses on why the men and women who support our troops in Iraq and Afghanistan, many of whom are former members of the military who reentered the war zone based on a sense of patriotic duty or economic necessity, are coming home only to battle insurers which deny them the medical care and benefits that American taxpayers have paid for, and why the same system richly rewards the insurance carriers for doing so.

Over 35,000 contractors have been killed or seriously wounded in Iraq and Afghanistan since 2002. In this subcommittee's investigation, we have heard story after story of injured workers coming home minus a limb or traumatized by war zone experiences seared into their psyche only to face the fight of their lives with their company's insurance carrier.

AIG's record is of particular concern given the enormous Federal subsidies it receives. It is already well known that AIG awarded hundreds of millions in bonuses to top executives who have led the company over the abyss. What this hearing will establish is that the same company has refused to pay the prescribed benefits to injured contractors without first putting them through a protracted fight. CNA, which is a much smaller player in the Department of Defense DBA market, nevertheless distinguishes itself for the lengths to which it will go to deny injured contractors' benefits and to deny the existence of the phenomenon.

This hearing will also demand to know where the Department of Labor has been since the start of the war to ensure injured workers are obtaining the benefits they deserve. The Department of Labor's Office of Workers Compensation Programs, which oversees the program, is drastically underfunded and understaffed. Its ability to oversee this exploding program has suffered as a result. But it is also clear that under the previous administration the Department of Labor took a hands-off approach to overseeing the DBA program.

We are going to look forward to hearing from Deputy Secretary of Labor Harris on how the Department of Labor intends to increase its oversight role and help improve the delivery of benefits to injured workers.

I hope this hearing will serve as an impetus for the reform of the Defense Base Act. Now I am going to welcome and yield to our ranking member. I would just like to say thank you for being here.

Before you arrived, Mr. Jordan, we did unanimous consent that all Members would have 2½ minutes, including us, in order to get to the witnesses. We welcomed without objection and under unanimous consent for Senator Sanders to join us.

So we will go to you for 2½ minutes, Ranking Member Jordan from Ohio.

[The prepared statement of Hon. Dennis J. Kucinich follows:]

Opening Statement
Of
Dennis J. Kucinich
Chairman
Domestic Policy Subcommittee

"After Injury, the Battle Begins: Evaluating Workers' Compensation for Civilian Contractors in War Zones."

Thursday June 18, 2009
2154 Rayburn HOB
2:00 p.m.

Good afternoon and welcome.

This hearing –"After Injury, the Battle Begins: Evaluating Workers' Compensation for Civilian Contractors in War Zones"– will evaluate workers' compensation insurance for federal contractors working oversees under the Defense Base Act, a little-known law passed in 1941 requiring all U.S. government contractors and subcontractors to secure workers' compensation insurance for their employees.

Last year, the full committee conducted an investigation and hearing focusing on the Department of Defense's Defense Base Act insurance program, which allows contractors to negotiate their own individual insurance contracts with

private insurance companies. It found this approach has produced a boondoggle for the insurance companies and the private contractors — and has saddled taxpayers with enormous costs.

Our own investigation has confirmed the full committee's findings: For the period 2002-2008, AIG averaged an annual profit rate of 35.7% from its DBA business, and CNA an annual profit rate of 50% from its DBA business with private contractors. These rates of profit are significantly higher than the profits typically earned by conventional workers' compensation insurers. Furthermore, these profits are subsidized by the Government, due to the fact that the Government absorbs part of the cost of the insurance from the federal contractor, and also reimburses insurance companies when a contractor's employee is wounded in a war-related injury.

As a result of the Committee's work last year, the Duncan Hunter National Defense Authorization Act of 2009 was signed into law on October 14, 2008 carrying a provision that requires the DOD to create a less costly strategy to

acquire insurance under the Defense Base Act. A report on this new strategy is due to congressional committees on July 13, 2009, and we expect it will detail how DOD intends to save taxpayers hundreds of millions of dollars.

Today's hearing focuses on why the men and women who support our troops in Iraq and Afghanistan – many of whom are former members of the military who reentered the war zone based on a sense of patriotic duty or economic necessity – are coming home to battle insurers which deny them the medical care and benefits that American taxpayers have paid for, and why the same system richly rewards the insurance carriers for doing so.

Over 35,000 contractors have been killed or seriously wounded in Iraq and Afghanistan since 2002. In 2007, the Department of Labor received over 10,000 new reports of injury and death under the DBA. The public interest news organization, ProPublica, analyzed Labor Department data and found that insurers had denied about 44% of all claims involving injuries involving more than four days of lost work. Insurance companies claim this number is a result of

DOL rules that force companies to deny claims first and then investigate later. These insurance carriers, however, are unable to provide data on their denial and litigation rates because, they unbelievably assert, they don't track them.

In this subcommittee's investigation, we have heard story after story of injured workers coming home minus a limb or traumatized by war zone experiences seared into their psyche, only to face the fight of their lives with their companies' insurance carrier. AIG's record is of particular concern given the enormous federal subsidies it receives. It is already well known that AIG awarded hundreds of millions in bonuses to top executives who have led the company over the abyss. What this hearing will establish is that the same company has refused to pay the prescribed benefits to an injured contractor without first putting them through a protracted fight? CNA, which is a much smaller player in the Department of Defense DBA market, nevertheless distinguishes itself for the lengths to which it will go to deny injured contractors' benefits and deny the existence of the phenomenon. Incredibly, a CNA representative represented to my staff that the company had

never received a complaint from an injured contractor. We checked up on this, only to find, to the contrary, that there are claimants currently appealing denials of benefits by CNA, and that the story of Timothy Newman, who will testify today that CNA denied him a prosthetic limb until a judge overruled CNA, is not unique. For that misrepresentation alone, I found it necessary to invite CNA to testify here today.

This hearing will also demand to know where the Department of Labor has been since the start of the war to ensure injured workers are obtaining the benefits they deserve. The Department of Labor's Office of Workers' Compensation Programs, which oversees the program, is drastically underfunded and understaffed – and its ability to oversee this exploding program has suffered as a result. But it is also clear that under the previous Administration, the Department of Labor took a hands-off approach to overseeing the DBA program. The Department has fined only a handful of companies, and has not pursued sanctions against companies which falsify claims information or fail to obtain workers' compensation insurance. There has also

been no interagency collaboration with the Department of Defense or Department of Justice, leading many to question: Who is in charge of this federal program? We look forward to hearing from Deputy Secretary of Labor Harris on how DOL intends to increase its oversight role and help improve the delivery of benefits to injured workers.

Finally, the Defense Base Act itself is flawed in that it was not written for an era where civilian contractors are relied on so heavily in a protracted war. The deficiencies in the Act impair both the ability of insurance companies to provide fair claims adjudication and the Department of Labor to act as an effective watchdog over the private insurance companies. I hope this hearing will serve as an impetus for reform of the Defense Base Act. [I am very happy to have Senator Bernie Sanders of Vermont here with me today – who has been at the forefront of efforts to reform the Defense Base Act and ensuring contractors are able to obtain the benefits they deserve.]

Mr. JORDAN. Thank you, Mr. Chairman. I have a short statement that I will read fast.

Thank you, Chairman Kucinich, for holding this hearing. I would like to especially thank the contractors who are here with us today for their service to our country. I look forward to their testimony.

As the battlefield has evolved, contractors are indispensable. Without contractors in Iraq and Afghanistan our troops would not have the food, shelter, supplies, or technology necessary to complete their 21st century missions.

Defense Base Act [DBA] insurance is statutorily mandated for contractors working on U.S. Government contracts overseas. In recent years we have seen costs increase as claims have increased. In a program as vast as DBA there are going to be failings. We need to do everything we can to correct those failings.

I hope this hearing will provide us an opportunity to survey the DBA program as a whole. It would be preferable to bring all parties, the Department of Labor, the employees, the contractors, and the five insurance providers, to the table to discuss where reforms are needed. Today, however, we will hear from only two of the five providers and none of the employers.

It is Congress's job to ensure the DOL has the resources and the statutory authority to educate contractors about DBA, facilitate information sharing between the contractors and the insurance companies, answer questions of statutory interpretation, adjudicate disputes in a timely manner, and oversee employee rehabilitation programs. I look forward to hearing what initiatives DOL has in place to make the DBA program more efficient.

Finally, I would like to express my disappointment that the investigation leading up to this hearing has not been completed in a bipartisan manner. The Republicans on this committee were not included in any of the preparations or deliberations leading up to this hearing. Consequently, as we sit here today, we are not as well positioned to educate our Members about this topic and not in a position to pass judgment on either the legitimacy of the contractors' claims or the propriety of insurance providers' decisions. I hope we can work more closely together in the future.

Again, thank you, Mr. Chairman. I look forward to the testimony.

Mr. KUCINICH. I thank the gentleman. The Chair recognizes Mr. Cummings for 2½ minutes.

Mr. CUMMINGS. Thank you very much, Mr. Chairman. Thank you for holding this critically important hearing to examine workers' compensation for civilian contractors in war zones.

I requested this hearing following the April 17th publication of an extremely troubling report by the Los Angeles Times in conjunction with ABC News and ProPublica that the health insurance claims of civilian contractors who participated in military operations in Iraq and Afghanistan are being consistently denied.

As you know, Mr. Chairman, civilian contractors, many of whom are veterans themselves, are serving an increasingly important role in achieving our mission in Iraq and Afghanistan. These brave men and women were alongside our uniformed service members consistently displaying acts of heroism on behalf of the American people. Tragically, recent news reports indicate that our commitment to

them does not parallel their commitment to their country. Just as there was public outrage over substandard conditions at the Walter Reed Medical Center, so too should we be appalled by the stories we hear today from civilian contractors who are injured on the battlefield and then abandoned here at home.

As you know, Mr. Chairman, the Defense Base Act [DBA], requires contractors and subcontractors to purchase workers' compensation insurance for employees working overseas. The insurance purchased must cover medical care and disability payments for workers injured in the performance of job duties. It must also provide death benefits for the families of employees killed on the job. The cost of insurance premiums paid by the contracting firms are then built into the price of the contract between the contractor and the Federal Government.

Right now, there are more than 31,000 current and continuing civilian injury claims as well as more than 1,400 claims for death benefits. The American International Group [AIG], and other insurers have received some $1½ billion in premium payments while paying out $900 million in compensation and expenses. What a deal. According to the April 17th article, AIG is a primary insurer retained by contracting firms handling some 90 percent of civilian claims filed in war zones in 2007.

I could go on but because of time, Mr. Chairman, I will submit my entire statement for the record.

[The prepared statement of Hon. Elijah E. Cummings follows:]

OPENING STATEMENT
OF
CONGRESSMAN ELIJAH E. CUMMINGS

"AFTER INJURY, THE BATTLE BEGINS: EVALUATING WORKERS' COMPENSATION FOR CIVILIAN CONTRACTORS IN WAR ZONES"

DOMESTIC POLICY SUBCOMMITTEE
OVERSIGHT AND GOVERNMENT REFORM COMMITTEE

THURSDAY, JUNE 18, 2009
2154 RAYBURN HOB
2:00 P.M.

Mr. Chairman,

Thank you for holding this critically important hearing to examine workers' compensation for civilian contractors in war zones.

I requested this hearing following the April 17 publication of an extremely troubling report by *The Los Angeles Times*, in conjunction with *ABC News* and *ProPublica*, that the health insurance claims of civilian contractors who participated in military operations in Iraq and Afghanistan are being consistently denied.

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important role in achieving our mission in Iraq and Afghanistan.

These brave men and women serve alongside our uniformed service members, consistently displaying acts of heroism on behalf the American people.

Tragically, recent news reports indicate that our commitment to them does not parallel their commitment to their country.

Just as there was public outrage over substandard conditions at the Walter Reed Army Medical Center, so too should we be appalled by the stories we will hear today from civilian contractors who were injured on the battlefield and then abandoned here at home.

As you know, Mr. Chairman, *the Defense Base Act (DBA)* requires contractors and subcontractors to purchase workers' compensation insurance for employees working overseas.

The insurance purchased must cover medical care and disability payments for workers injured in the performance of job duties; it must also provide death benefits for the families of employees killed on the job.

The costs of insurance premiums paid by the contracting firms are then built into the price of the contract between the contractor and the Federal Government.

Right now, there are more than 31,000 current and continuing civilian injury claims, as well as more than 1,400 claims for death benefits.

The American International Group, Inc. (AIG) and other insurers have received some $1.5 billion in premium payments, while paying out $900 million in compensation and expenses.

According to the April 17 article, AIG is the primary insurer retained by contracting firms, handling some 90 percent of civilian claims filed in the war zones in 2007.

The article goes on to describe the difficulty that claimants have encountered in receiving benefits for medical care and disability payments, as well as the challenges faced by the families of those killed in receiving death benefits.

From prosthetic limbs to treatment for Post Traumatic Stress Disorder, the claimants have faced a "reject first and investigate later" mentality from the insurers.

In order to receive their legally mandated compensation, claimants often have to resort to mediation or litigation.

Mr. Chairman, we can do better.

I look forward to the testimonies of today's witnesses and yield back the remainder of my time.

ELIJAH E. CUMMINGS
MEMBER OF CONGRESS

Mr. KUCINICH. Without objection, the gentleman's statement will be submitted to the record. I will submit my entire statement for the record as well.

The Chair recognizes Senator Sanders from Vermont for 2½ minutes.

Senator SANDERS. Thank you very much, Chairman Kucinich and Ranking Member Jordan. Thank you very much for the opportunity to say a few words. What we are looking at is an horrendous situation in two regards:

Most importantly, men and women who have put their lives on the line in Iraq and Afghanistan, civilians working for private contractors who have been wounded, came home with the expectation that they would get the care and the benefits that they were entitled to. What we are seeing is time and time again large insurance companies like AIG are denying them the benefits that we have paid for as taxpayers. That is issue No. 1.

Issue No. 2 is that at a time when this country has record breaking deficit and an $11 trillion national debt, it is our obligation to make sure that taxpayers' money is well spent. I think any serious investigation of how money for workers' compensation, in terms of these private defense contractors, has been spent will indicate that there has been huge wartime profiteering. That is an abuse of taxpayers' money that is not acceptable.

Clearly, under the last administration there was virtually no oversight in terms of the Department of Defense and the Department of Labor. So I think the time is long overdue for us to take a very hard look at the Defense Base Act and to make sure that all of those men and women who are hurting today get the care that they need. And we have to make sure that we are not continuing to waste billions of dollars of taxpayer money.

Thank you, Mr. Chairman.

[The prepared statement of Hon. Bernard Sanders follows:]

Statement
Of
Senator Bernie Sanders

Joint Hearing
Oversight and Government Reform Committee
Domestic Policy Subcommittee
Thursday, June 18, 2009
2154 Rayburn HOB
2:00 p.m.

Thank you, Chairman Kucinich and Ranking Member Jordan, for inviting me to join your panel this afternoon. This issue of overpayment for workmen's compensation and the unfair treatment of wounded contract employees in Iraq and Afghanistan is something my office has worked on for awhile and I appreciate being able to make a brief statement.

We are here today to talk about a little known law that has had huge consequences for many civilian employees who served during the Iraq and Afghanistan wars. There are 190,000 individuals who have kept our soldiers fed, clothed and supplied. These are the people who drive trucks in convoys, and repair the equipment. These are the people who live in war zones for months at a time. And sometimes, these civilian employees get hurt, or even killed. That is when the workers compensation program comes into play.

Let's be very clear: our workers compensation system for civilian employees in war zones is broken and needs fundamental repair.

This broken system – the Defense Base Act Workers Compensation Program - has resulted in tens of millions of dollars in wasteful spending. With record breaking deficits, this is something our nation can ill afford. Worse, the same broken system has meant that too many civilian contract employees who risked their lives and saw harm in Iraq did not receive the medical care and support they deserved and needed. Some of our witnesses today are going to make that point quite strongly and we thank them for being here.

Bloated Profits and Pentagon Waste

Our nation has spent an enormous amount of money for the wars in Iraq and Afghanistan. In general, the government has done a very poor job ensuring accountability for the billions we spend every month. That is especially clear when we examine the Defense Base Act and analyze what happens to the billions they have been spent in premiums for workers' comp insurance for civilian workers in war zones.

Army audits and the Government Accountability Office (GAO) have called into question the price of the insurance, as well as the oversight of the insurance payments and premiums. The Army Audit Agency said in 2007 that "Overall, we concluded that adequate controls weren't in place to make sure that costs for DBA insurance were minimized under the LOGAP contract." They went on to say that, "As a result of these conditions, we believe there's a high risk that the contractor may have been paying more than necessary for this insurance."

In May, 2008, the Government Accountability Office reported that the DOD could not even account for how much we spend on workers compensation insurance, saying that, "The total cost of DBA insurance to the government or the extent to which Iraq reconstruction funds were being spent on DBA insurance could not be calculated . . ."

But here is what we do know.

Insurance companies have charged monthly premiums at a rate much higher than appropriate. There are few specific numbers available, in itself a serious problem, but the profit levels just for AIG in their dealings with KBR are on the order of $100 million on a $292 million cost plus multi-year contract. Workers compensation companies providing insurance in Iraq and Afghanistan have made underwriting profits of $600 million on $1.5 billion in premiums. This was the analysis of this committee last year.

By the way, most of the Defense Base Act was handled through one insurance carrier, the Insurance Company of the State of Pennsylvania, *a subsidiary of insurance giant AIG.*

Clearly, this is a multibillion dollar program that needs fundamental reform.

On Friday, the Defense Contract Audit Agency, the audit arm of the Pentagon, did the right thing and recommended that the Department of Defense stop workers compensation premium payments to KBR. Why? Because the Audit Agency has yet to see evidence that the insurance premiums were reasonable for contract payments dating back to 2004.

Department of Labor Lack of Oversight

Unfortunately, the lack of federal oversight does not stop with the Pentagon. During the entire war, the Department of Labor under the previous administration failed to perform basic oversight. The Department of Labor's responsibility is to ensure that insurance companies provide the support and health care payments that workers injured in Iraq deserve. Too often this was not the case.

My hope is that the new Department of Labor, under Secretary Hilda Solis, will take a new look at this issue and the Defense Base Act and move forward aggressively in addressing the problems of the past as they protect the tax payers of our country and, even more importantly, those civilian employees who put their lives on the line for this country.

Mr. KUCINICH. Thank you very much, Senator Sanders.

We are now going to go to our witnesses since there are no further comments from Members. I want to start by introducing the first panel. Seth Harris was sworn in as Deputy Secretary of Labor on May 26, 2009. You have an extensive background, which we will submit for the record, but in the interests of expediting this hearing we are going to go to your testimony.

It is the policy, Mr. Harris, of the Committee on Oversight and Government Reform to swear in all witnesses before they testify. I ask that you would please rise and that you would raise your right hand.

[Witness sworn.]

Mr. KUCINICH. Thank you. Let the record reflect that the witness answered in the affirmative.

Mr. Harris, all witnesses were invited to give a 5-minute statement. I think it is a good idea that we try to stick to that. So, would you proceed with a 5-minute statement? In any event, your entire statement will be included in the record.

We would like to hear from you and then we are going to immediately go to questions of you from the Members. Then after that we will go to the next panel.

Thank you very much.

STATEMENT OF SETH D. HARRIS, DEPUTY SECRETARY, DEPARTMENT OF LABOR

Mr. HARRIS. Thank you, Mr. Chairman. Thank you, Congressman Jordan, Senator Sanders, Congressman Cummings, and the other members of the subcommittee. As the chairman said, my name is Seth Harris. I am the Deputy Secretary of Labor. As the Labor Department's Chief Operating Officer, I oversee the Office of Workers' Compensations Programs administration of the Defense Base Act. I am grateful for this opportunity to discuss the Department's role and responsibilities under the DBA and the values we bring to the discussion of how we might reform this important program.

Let me begin by thanking Chairman Kucinich, Senator Sanders, and the other members of the Domestic Policy Subcommittee who played a leadership role on this issue. You have raised important issues about the operation of the DBA program and put the program on the path toward reform. Through your efforts and the diligent work of your staff, the issues are being explored and the program's problems are being brought to light.

The Defense Base Act needs significant reform. The Department of Labor looks forward to working with you and other agencies of Government to diagnose honestly the problems in the program and to craft the right solutions to those problems.

I would also like to take a moment to recognize and express my respect for the civilian contractors who will address you this evening and in the process represent thousands of others who were injured or killed while giving support to our armed services and civilian agencies. The Workers' Compensation program they relied on to care for them in their time of greatest need did not work as well as it should have. They deserve better. Now, we must build a better system for them and for future claimants.

Mr. Chairman, the Department's goal is to reduce the consequences of work related injuries. Civilian contractors who work overseas in support of our military and civilian agencies should receive prompt and appropriate benefits to remedy the physical, psychological, and financial effects of injuries that happen in the course of their employment. Employees should know what benefits they may be entitled to and how to get them. Employers and their insurance carriers should have systems in place to respond to injury claims and voluntarily provide necessary medical benefits and monetary compensation for disability or death as quickly as possible. I look forward to working with you to build a Defense Base Act system that serves those values better than the system we have today.

The Department of Labor recognizes that the DBA, under the extreme and evolving conditions in which it is now applied, is insufficient to meet the needs of its major participants. Written in 1941, the DBA was designed to protect a small cadre of American workers primarily engaged in engineering and construction work in Europe and the Pacific. Now, the program serves an enormous international work force engaged in nearly every imaginable type of occupation.

They are employed by both American and foreign companies large and small. There are multiple layers of subcontracting. And to further complicate matters, contractors serve in distant countries with major language, culture, and infrastructure challenges. In many cases, they serve in war zones and face the persistent threat of grievous injury from new types of insidious attacks, sometimes with limited medical care availability and the added challenges of evacuation.

The Department of Labor knows about these difficulties but we are trying to meet a complex 21st century challenge with a program from World War II. It simply isn't up to the task. Fundamental reform is needed. The Department has made every effort to implement the DBA fairly and effectively. However, it is my sense that even with additional resources, more modern technology, and redoubled effort by all concerned the Department's effort would be insufficient to overcome the systemic challenges now facing the DBA. We have already begun evaluating alternative approaches with the contracting agencies.

The present structure of the DBA insurance program is characterized by severely limited competition in the insurance market, varying premium rates, procurement of insurance through widely divergent processes, and significant limitations on the ability to track and account for the contractors, subcontractors, and contract workers involved. These systemic problems raise serious questions about a whole range of issues.

I have a long list of questions, Mr. Chairman, which we can come back to if you would like in questioning but I don't want to go over my time.

The list of problems with the existing DBA program, along with others that are not on my list, is extensive and troublesome. However, the list of options to address these issues provides various paths to change and we believe improvement in the DBA program. We see four basic options with flexibilities within each:

First, Congress could decide to leave the basic structure as is but revise specific sections of the law to clarify, strengthen, and reform identified weaknesses and define what is not clear.

Second, Congress may decide to replace the existing system with an option for the contracting agencies to self insure their contracts instead of procuring private insurance or to remain in the private insurance system that currently exists.

Third, Congress may decide that the entire Federal program should be self insured under one entity with no option for private insurance.

Fourth, Congress may decide to simply leave the DBA statute as is but provide additional resources to strengthen the oversight, regulation, enforcement, and reporting processes.

The most important step the Labor Department can now take is to work closely with this subcommittee and the contracting agencies to analyze these options and determine which will best serve the civilian contractor work force. We are committed to taking that step.

Mr. Chairman, I look forward to your questions and those of the members of the panel.

[The prepared statement of Mr. Harris follows:]

STATEMENT
OF
SETH D. HARRIS
DEPUTY SECRETARY
U.S. DEPARTMENT OF LABOR

DOMESTIC POLICY SUBCOMMITTEE
OVERSIGHT AND GOVERNMENT REFORM COMMITTEE

Thursday, June 18, 2009
2154 Rayburn HOB
10:00 a.m.

Thank you, Mr. Chairman. My name is Seth Harris. I am the Deputy Secretary of the Department of Labor. The Department's Office of Workers' Compensation Programs (OWCP) is responsible for overseeing, among other workers' compensation activities, the provisions of the Defense Base Act (DBA) and the War Hazards Compensation Act (WHCA).

I appreciate this opportunity to appear before you today to discuss the Department's roles, responsibilities, and values as applied to these statutes. The OWCP shares the Committee's concern that civilian contractors who work overseas in support of our military and civilian agencies are not in all cases receiving prompt and appropriate benefits to remedy the physical, psychological and financial effects of injuries that happen in the course of their employment. Employees should know what benefits they may be entitled to and how to access them. Employers and their insurance carriers should have systems in place to respond to injuries and should voluntarily provide necessary medical benefits and monetary compensation for disability or death as quickly as possible. Reducing the consequences of work related injuries is OWCP's primary goal. I look forward to working with Congress and our stakeholders to ensure that injured workers and their families receive the benefits to which they are entitled, and to address the obstacles employers and their insurers encounter in delivering benefits to injured workers.

The 1941 Defense Base Act (42 U.S.C. § 1651 et seq.) is an extension of the Longshore and Harbor Workers' Compensation Act (Longshore Act) (33 U.S.C. § 901 et seq.). The DBA covers all workers, regardless of nationality, who are injured or die while working overseas under contract to federal agencies. Since 1950, the DBA has been administered by the Department of Labor (DOL). Like state workers' compensation systems, benefits under the DBA are paid by private insurance companies. The cost of the premiums for the DBA insurance policies is included in the contracts let by the federal agencies. The costs of benefits paid by

the insurer for DBA claims arising from a war-risk are eligible for reimbursement by the federal government under the War Hazards Compensation Act.

From an obscure program with no more than a few hundred claims a year, the Defense Base Act has undergone a significant expansion in recent years, as contractors have taken on an ever-increasing role in supporting our war and reconstruction efforts in Iraq and Afghanistan. In 2007, OWCP received over 10,000 new reports of injury and death under the DBA. Originally established to protect a much smaller and more homogenous group composed primarily of engineers and construction workers, the DBA program has been hard-pressed to successfully support the efforts of two hundred thousand workers, many on the front lines in combat zones, engaged in nearly every type of work. Although the Department of Labor has worked hard to see that prompt and appropriate benefits are delivered under this statute, and we believe that the majority of participants in the DBA program have as their goal effectively addressing the needs of our civilian contractors working in war zones, we acknowledge that significant problems have been identified in several important aspects of the program.

Congress has clearly communicated its concern about the cost of DBA insurance and has directed the Department of Defense (DOD), the largest DBA contracting agency, to study alternative approaches to procuring such insurance. DOD will be submitting a report to Congress on cost issues in July 2009. DOL has provided technical assistance to DOD and other contracting agencies in their evaluation of various procurement options and insurance acquisition strategies. DOL will continue to do all we can to assist in this effort. There are a variety of alternative approaches, each with its own sets of strengths and weaknesses, and I will address some of them later in my statement.

Other critical administrative issues must be addressed. These include making sure that insurance coverage is obtained for all contractors and subcontractors; helping workers understand their rights under the DBA; and reducing the delays and disputes that occur in the claims process.

When reconstruction efforts began in Iraq in mid-2003 and increasing numbers of civilian contractors were deployed overseas, DOL recognized the need to educate contractors, subcontractors, contracting agencies, and insurance brokers to ensure that all had appropriate DBA insurance coverage. There are a number of unique obstacles and challenges that make this effort especially difficult. One is the involvement of overseas contractors with no presence in the United States, making effective communication extremely difficult. Distance, language differences, time differences, and lack of local infrastructure magnify these communication difficulties. Prolific and layered subcontracting, down to the smallest local 'Mom & Pop' business that actually provides, for example, janitorial services on a military base in rural Iraq, makes ensuring universal coverage nearly impossible. DOL has made efforts through the contracting agencies and the prime contractors to communicate the DBA's insurance

requirements to all subcontractors, but DOL is limited in its ability to guarantee that all employers have the necessary insurance, as there is no comprehensive system for tracking overseas contracts, contractors and subcontractors, and workers under each contract. While the prime contractor may ultimately bear the risk for any losses when a worker for a small local subcontractor suffers injury, it is sometimes difficult for DOL staff to identify the employer, the prime contractor, and the responsible insurance carrier. This can make claims investigation time consuming because establishing the employment relationship is a prerequisite to benefit eligibility. A related problem arises when, in the competition for subcontracts, some companies decide to go without insurance in order to lower their costs. Identifying uninsured employers is difficult in the best of circumstances – adding small foreign subcontractors to the equation magnifies the challenge. The Department of Defense, the State Department, and USAID have recently implemented a data system to track contractors and contractor personnel operating in Iraq and Afghanistan. DOL plans to work with these agencies to leverage this data and improve compliance with DBA insurance requirements among contractors and subcontractors.

Ensuring that all covered workers understand their rights under the DBA is similarly problematic. While communicating with American employees of major contractors is relatively straightforward, reaching foreign workers from countries around the globe, employed many subcontracting levels below the prime contractor, is especially complicated. In one instance, the United States prime contractor subcontracted with a company in Nation A to transport supplies. The subcontractor then hired employees from Nation B to transport supplies from Nation C, across Nation D, and into Nation E. These circumstances are not unique. DOL has addressed this challenge by educating agency contracting officials and prime contractors of the need for DBA insurance through each level of subcontracting; by making it clear to the prime contractors and their insurance carriers that it is their responsibility to provide DBA information to covered workers; and by posting on the DOL website information about the DBA and the claims process, both in English and in Arabic.

One of the Department of Labor's strategic goals is to "Reduce the Consequences of Work Related Injuries," and we have been directing our efforts toward improving the delivery of benefits. The Department oversees benefit delivery by receiving and monitoring reports of injury and of benefit payments, and providing informal but critical dispute resolution services. We educate the various participants about their rights and responsibilities under the DBA, and provide technical and compliance assistance whenever necessary. Our district directors and national office managers regularly speak at industry conferences and seminars to highlight current trends and recommend improvements in claims handling practices. We maintain a robust website to provide claim and insurance information to program participants, including Arabic translations of key DBA information and claim forms.

We also monitor the claims decisions of the insurance industry through our review of individual claims records, and provide corrective guidance and compliance assistance when we discover errors and omissions. For example, if an insurance company reports that benefits are being paid at an incorrect rate, our district office claims examiners notify the parties of the error and request an immediate adjustment. If benefits are suspended based on erroneous or missing medical documentation, we recommend that benefits be continued pending submission of the requisite reports. Reminders are issued to insurance companies if required claims actions are not performed when due. If any dispute arises or if either party to a claim fails to respond appropriately, we convene an informal conference to discuss and resolve issues.

The issue of Post-traumatic Stress Disorder (PTSD) claims provides a good example of DOL efforts to improve outcomes under the Defense Base Act. In early 2006, when the inventory of PTSD claims began to rise, we convened a meeting with insurance industry leaders to heighten their awareness of the issue, address common problems encountered by the claims handling community, and share resources and best practices in resolving these complex claims. We continue to monitor the industry's progress with this type of claim to see that they are handled in accordance with law, but also in a sensitive fashion given the war-zone source of many such claims.

To strengthen our claim monitoring efforts, we redistributed DBA claims from the initial intake in the New York district office to district offices around the country. Injured U.S. workers now have access to our district office personnel located closer to their residence. All district office staff also receive training in the best DBA claim practices based on the work done in our New York office, which has the most experienced DBA staff.

Issues have been raised with respect to the execution of the claims process. We have worked hard to improve our internal processes to meet the needs of claimants and to assist the insurance industry in meeting its obligations. Despite the age-old tradeoff between labor and industry at the heart of workers' compensation -- predictable benefits in exchange for foregoing tort lawsuits – most workers' compensation systems remain inherently contentious. Insurance companies are required to pay only the claims that meet certain legal criteria, that is, the medical condition must be related to employment and the disability must be supported by medical evidence; thus, insurance carriers investigate claims thoroughly before authorizing benefit payments. Under normal conditions, this can result in delay; given the nature of claims under the DBA, the delay can be extensive. The nature of some injuries, especially those of a psychological nature such as Post-traumatic Stress Disorder, can make investigation time-consuming and dependent on difficult-to-obtain supporting medical reports, at times resulting in frustration for all involved. That the traumatic incident occurred in a foreign country, thousands of miles from the United States, sometimes in the fog of war,

with little local infrastructure for investigation and reporting, makes the claims adjustment process even more challenging.

As in any workers' compensation system, the DBA insurer relies on factual and medical evidence to establish claim eligibility, both initially to satisfy threshold requirements and subsequently to establish continuing eligibility for benefits. Some of the delays in carrier claim decisions are due to the complexity of the underlying entitlement issues that often depend on expert medical opinion for resolution. The medical sector does not always work with the speed that our stakeholders expect or want. Evaluation and testing, treatment, discovery, and reporting all take time; securing competent medical opinions from overseas is frequently difficult. While the DOL has found no deliberate intent to delay claims handling, we have discussed and will continue to discuss with insurers the amount of time required by some claims adjusting behavior.

The recent media coverage of several injured contractor employees highlighted some of the systemic problems with the DBA claims process. In the majority of these cases, the insurer voluntarily paid compensation and medical expenses without a formal award once the employer reported the injury, and those outcomes reflect how the system should work. In one case, the injured worker received vocational rehabilitation services from DOL and returned to work with another stateside employer. However, disputes subsequently arose regarding various aspects of these claims. OWCP claims examiners promptly conducted informal conferences and in most cases issued recommendations favorable to the claimants. If the parties still were unable to resolve the issue in dispute, the case was promptly referred to the Office of Administrative Law Judges (OALJ) for formal hearing. In two cases, disputes arose after the ALJ had entered an award of benefits; one was resolved after an informal conference; the other required a second referral to the OALJ.

We continue to work on our ability to monitor, measure, and improve the claims processes in the DBA program. We are establishing new performance measures for the program, with plans to produce and publicize an 'Industry Report Card,' which will measure how quickly insurers and self-insured employers report injuries and initiate payments. We have just added a large number of "Frequently Asked Questions" to our website to educate and assist all program participants in the claims process. Information available on the website includes a basic discussion about DBA coverage and a reference for contractor employees on how and where to report an injury and file a claim. Quarterly statistics on injuries and deaths as captured in DBA case reports will also be available.

DOL is committed to improving the DBA program to meet participants' needs while working to reduce claim delays, and meet other challenges. In light of increasing claims volume, claim complexity, and escalating demands for detailed reporting, DOL is reviewing the adequacy of its existing data system used to monitor DBA activity. We will look for opportunities to upgrade and strengthen

that data system. DOL will also emphasize its educational and technical assistance role by continued improvements to its website. In addition, DOL will study the feasibility of educating and certifying claims adjusters who work for private DBA insurers, setting benchmarks to monitor their claim-handling proficiency and providing for decertification of those claims adjusters with substandard performance.

Despite our efforts to improve various administrative aspects of the DBA program, some problems persist both with insurance and claims administration. Some of the insurance problems may be addressed when the DOD presents its proposals to Congress later this summer. Other problems are inherent to DBA claims and are not easily susceptible to administrative remedy.

On the insurance side, DOL's viable options for encouraging carriers to timely process claims or keep premium costs down are limited. DOL can only authorize insurers to write DBA insurance if they are authorized by at least one State, a United States territory, or the District of Columbia to write workers' compensation insurance. Foreign insurance companies cannot, therefore, cover DBA. Many of the authorized companies will only accept U.S. risks because they are not equipped to cover overseas employers, limiting the market for foreign employers. DOL has no authority to set or oversee premiums; although DOL may refuse reimbursement of a war hazards claim if OWCP were able to determine that the DBA premium included an additional charge or loading for such hazard. While DOL may suspend or revoke an insurance carrier's authorization to write DBA insurance for good cause, this remedy leads to a reduction in the available market (only three companies currently write the vast majority of DBA policies) and may lead to corresponding upward pressure on prices.

Further, local companies in Afghanistan and Iraq may be declined by U.S. insurers because their underwriting profile is unsuitable or, given the increase in DBA claims generally, U.S. insurance companies may not have the capacity to accept these additional risks. Since there is no market of last resort—similar to state-assigned risk pools—that would allow an employer to buy insurance from a designated DBA insurer if no other coverage is available, foreign companies may be excluded from the contracting process altogether.

One common complaint among smaller contractors is that most insurers require a minimum premium to cover their administrative costs. This means that absent a single source contract obliging the insurer to accept all risks at the same rates, small contractors with a limited scope of work are charged disproportionately high rates, even assuming they would otherwise have access to DBA insurance.

As local subcontracting proliferates, we encounter more instances of uninsured employers who either are not aware of the DBA insurance requirement or who believe that DBA insurance is not required. By law, an uninsured employer is responsible for payment of DBA benefits. When payment of benefits cannot be

enforced against any employer, claims are paid as a last resort from a Special Fund, which receives assessments levied on all carriers and self-insurers under the Longshore Act and its extensions. The increasing financial burden resulting from uninsured employers would thus fall on private-industry members, many of whom have no connection with work performed overseas but rather are stevedoring, ship building and ship repair companies.

Another potential problem confronting the current system is the financial security of the insurance carriers themselves. State guaranty funds, which protect employers under their local workers' compensation statutes, do not cover DBA risks. DOL requires insurers, as a condition of their continuing authorization, to post security based on their outstanding DBA-benefit obligations. If a carrier becomes insolvent, the employer is bankrupt, and the security is exhausted, the Special Fund would once again become the payor of last resort. Thus, under the current scheme, the cost of civilian contracting would be passed on to private industry in the U.S. that has no connection to the work performed overseas.

The claims administration side of the DBA system has its problems too. The lack of a comprehensive system of tracking overseas contracts, contractors and multiple layers of subcontractors, and workers under each contract limits DOL's ability to ascertain contractor compliance with the DBA insurance requirement. It also impedes the prompt and accurate identification of the insurer responsible for each covered injury. This problem may be alleviated if there were a central system for securing insurance and reporting and tracking injuries that may be utilized across contracting agencies and DOL. DOD, DOS, and USAID have established a joint tracking system for their contractors and contractor personnel in Iraq and Afghanistan, and this will go a long way to facilitate matching injured workers with their responsible employers in case of injury.

Without an efficient system for reporting injuries and deaths, delays in claim investigation and early claim resolution arise. This problem is particularly acute among small local subcontractors who do not understand the concept or the requirements of workers' compensation coverage. Further complications include the difficulty of providing foreign workers with clear information about the DBA, the lack of local resources to assist in filing claims, and language barriers.

Finding a comprehensive solution to these insurance and claims processing problems has proved challenging. Using a single-source-insurance provider such as the State Department and the Army Corps of Engineers currently have in place overcomes the problems associated with access to insurance and minimum premiums; the insurer must accept all risks at the same rates set by the contract. But the single carrier needs to demonstrate that it has both the financial capacity and claims handling ability to service the contract. Currently, only one company (CNA) is bidding on these contracts. If that company does not wish to renew, the single-source option may no longer be viable or not as attractive. Also, since single-source contracts are agency specific, employers who contract with more

than one agency may be covered for DBA liabilities by two different insurers, creating another problem when injuries occur. For example, an employer providing personnel to two agencies with different insurers might assign the same worker on a rotating basis between the two agencies. If the worker was killed in the line of duty, it may not be immediately apparent which insurer should respond, although the right to benefits is beyond doubt. Also, a single-source insurance program does not cure the problem of a contractor's failure to secure DBA insurance, and does not guarantee the long term financial soundness of the single source provider.

Another insurance strategy that has been under consideration is a government-wide self-insurance plan. This option would create an entity similar to a state insurance fund or a private captive insurance company which would automatically extend DBA insurance protection to all eligible contracts, subcontracts, and locations overseas and cover all employees working under those contracts and in those locations. There would be no individual insurance policies. Instead, there would be blanket insurance coverage for all DBA risks. This plan would alleviate most of the problems discussed above, and would also minimize the disparity in claims handling by different insurance carriers and reduce the incentive for litigating disputes. The cost of workers' compensation benefits would flow directly back to the contracting agencies, without the added layers of profit markup by the contractors, insurance brokers, and insurance carriers. It would also eliminate the need for a separate war risk hazard determination (currently the costs under the War Hazards Compensation Act are paid out of the Federal Employees' Compensation Fund and not charged back to the agencies).

Additional options being considered would require devoting more resources to delivering benefits to injured overseas workers and their families. While insurance companies have been hiring overseas adjusters to assist in the claim-filing and investigation processes, more could be done, such as providing contracting agency staff at local embassies to provide additional support. DOL will also explore ways to improve the dissemination of DBA insurance information to the smaller local subcontractors through the contracting agencies and the insurers.

Among the challenges participants experience in the DBA system are delays and the length of time required to navigate the dispute resolution mechanism. Although DOL provides an effective and efficient informal dispute resolution service that resolves disputes in an average of about eight months, cases that require formal litigation may take much longer. Further, for claims arising from a multi-national workforce deployed around the globe, support systems to assist in perfecting a claim, presenting necessary documentation, and engaging in appeals -- e.g., union representation and access to an effective plaintiff bar -- may not be available. Consideration could be given to decoupling the DBA adjudicatory process from the standard Longshore Act requirements to offset these deficiencies. Revisions might be made to the DBA that would streamline the

adjudication processes, enhance the ability of overseas claimants to participate in the informal resolution system, enhance some of the benefit payment requirements, provide incentives to insurers for prompt decision making, and reduce the need for litigation. DOL will be pleased to work collaboratively with the contracting agencies, insurance companies, claimant attorneys, and Congress to draft proposals to achieve these improvement goals.

Mr. Chairman, the Department of Labor has initiated conversations about alternatives that might improve the functioning of the Defense Base Act with the primary contracting agencies, including Defense, State, and USAID. We look forward to the DOD report on its analysis of insurance options to be submitted to Congress in July 2009. We will continue to work to improve our oversight of the current system, but we would welcome the opportunity to participate in additional dialogue about enhancing that system.

Mr. KUCINICH. I thank the gentleman. We are going to now move to questions from Members.

I would just ask the witness and all other witnesses who will come in other panels that when you are asked questions by Members, please answer the question directly. Be as succinct as you can in the interest of trying to get as much of the information that you have available to members of this committee.

I would like to begin by talking about the Office of Workers' Compensation. I understand this Office has been underfunded for the past 8 years. But does the Department of Labor really maintain records showing insurance coverage with such advanced technology as this 3x5 card? It says here this form was last updated in 1976. Is this the way you keep records there?

Mr. HARRIS. Yes, Mr. Chairman. You are right that card dates from the Ford administration.

Mr. KUCINICH. Is it time to upgrade the system?

Mr. HARRIS. It is time to upgrade that system and we are going to fix that. We have a plan that we are ready to implement and we are going to fix that system.

That is the card on which we receive information from the insurers about who they have covered. We have a long stack of those cards that we use to get this information.

Mr. KUCINICH. Would you agree that if you have a lot of claims, wouldn't it be important to the claimants to be able to have their data into a reliable and sophisticated data collection system?

Mr. HARRIS. I think that is right. But let me say, that card isn't for claimant data. That card is for insurers' coverage of employers.

Mr. KUCINICH. So you are saying, you are committing that you are going to update it?

Mr. HARRIS. We are going to fix it. Absolutely, yes.

Mr. KUCINICH. Now, I want to ask you also, your staff has made some disconcerting statements about the Department of Labor's authority to enforce DBA requirements. One staff member referred to the Department of Labor in these terms, that you are "at best a score keeper, not really a referee." We know the difference between a score keeper an a referee. Another staffer said that Congress intended the DBA program to be self executing where DOL only sits back and watches and jumps in when something goes bad.

Do these comments represent accurately the current administration's view about its responsibility for DBA workers' compensation insurance?

Mr. HARRIS. No.

Mr. KUCINICH. Will you change DOL's policy and culture so that the Department of Labor exercises more authority?

Mr. HARRIS. Well, the statute defines the scope of our authority. The descriptions that you just repeated from members of my staff, and I would be curious to know who they are, by the way, I don't think accurately capture what our statutory role is.

Mr. KUCINICH. But the Department of Labor has a poor record of overseeing DBA insurance. That is a legacy you do not want to repeat, I take it?

Mr. HARRIS. Well, I don't want us to do a poor job. That is certainly true, Mr. Chairman.

Mr. KUCINICH. Are you going to assure this subcommittee that you are going to conduct a top to bottom review of the Department's of Labor role in administering the DBA insurance?

Mr. HARRIS. Well, I think the most productive thing we can do, Mr. Chairman, is to work with you to fundamentally change the program. I think that there are a lot of administrative reforms we could make and we should do those. But let me say, the program is not designed for the circumstances that we are in right now. What we need is fundamental reform.

I think more resources, better technology, better systems might improve the circumstances somewhat. But let me say, for the folks who are going to be testifying on your next panel, I am not sure any of those processes would have changed the outcome in their particular cases. It is the system that we have, a system that depends upon private insurance, that is an adversarial system, like many workers' compensation systems, unfortunately, and a system that results too often in adjudication that takes months and months and months and months.

Mr. KUCINICH. But it is true if you are working with old technology, that can slow down claims. If you have insurance companies that don't want to pay the claims and a technology that slows down the claims, you are going to have frustration in the first case of people not getting their case in front quickly enough and in the second case of just the insurers not wanting to pay. That is the concern that we have.

Mr. HARRIS. Well, I share the concern that the technological problems or the systems that we are currently using result in some delay. But let me say, I don't think that is where the bulk of the delay in this system comes in. It is when you end up in an adversarial relationship between the insurer and the claimant.

Mr. KUCINICH. Let me talk about that, if I may, because my time is running out to ask you questions. What are the limitations in the DBA that prevent the Department of Labor from playing an active watchdog role?

The act specifically states that the Department of Labor may "provide persons covered by this act with legal assistance in processing a claim." On DOL's Web site it states, "Department of Labor administers the Defense Base Act ensuring that workers' compensation benefits are provided for covered employees promptly and correctly." Please, if you could respond briefly?

Mr. HARRIS. Yes. The role of the Labor Department is to process these claims; when there are disputes to mediate between the insurer and the claimant; to cajole, pressure, beg, or beat about the head and neck the insurers who are denying claims; and to get to settlement as quickly as possible.

We are not, however, an arbitrator or a judge. There is an adjudicative process that follows. When the Office of Workers' Compensation Programs advocates on behalf of a claimant and the insurer still refuses to pay, we end up with a referral into adjudication. That is where I think the delays come in.

Mr. KUCINICH. I thank the gentleman. The Chair recognizes the Minority Leader, Mr. Jordan.

Mr. JORDAN. Thank you, Mr. Chairman. Mr. Harris, did I get that right when the chairman introduced you that you have been on the job 3 weeks?

Mr. HARRIS. It seems a lot longer but yes. It has been about 3 weeks.

Mr. JORDAN. Well, Mr. Chairman, some of the line of your questioning I think was right on target. This is the second hearing I think we have had in 6 weeks which dealt with a program at the Department of Labor. Nothing against Mr. Harris, but he has been on the job 3 weeks. I think 6 weeks ago when we had the hearing on the H–2B Program we had no one from the Department of Labor here to talk about what was going on there and the lack of oversight that they had there. This is serious.

Mr. Harris, in your testimony you talked about four approaches that would help improve this entire operation. I just jotted them down because I didn't have your testimony directly in front of me. You said one was to kind of define, clarify, refine how the current system works. I think the other one you said was to allow employers to self insure. The third option was to have the entire system in some kind of self insurance. Then the fourth one was more dollars. More resources I think was your term. Walk me through those real quickly. Which do you advocate and which do you think makes the most sense? Give me your thoughts on those.

Mr. HARRIS. I thank you for that question. Let me just, if I could, modify your description of the second option a little bit. It would be the contracting agencies that would have the option of self insuring rather than employers. There is some self insurance by employers here that are not insured.

Each of these options serves different purposes and accomplishes different results. So the question is what problems are we most interested in trying to solve. If the principal problem that we are trying to solve is that this is an insurance market that doesn't have enough participants, a uniform self insurance system might well be the way to go.

But we need to engage with the contracting agencies. The Department of Defense is going to come forward with a report in July. We need to engage with them to try and winnow down these four. But I think that what we are trying to suggest to the committee is that these are four options with variations within each of them that I think that the committee should be thinking about as it considers legislation.

Mr. JORDAN. But the question, I guess, is which one do you advocate?

Mr. HARRIS. We are not advocating for any of the four just yet. We need to engage the contracting agencies before we are prepared to do that.

Mr. JORDAN. The study is coming back when, next month?

Mr. HARRIS. My understanding is that the Defense Department is going to be reporting on July 13th about this program and about the scope of contracting.

Mr. JORDAN. We will look forward to that study. When the United States first went into Iraq and Afghanistan, many of the defense contractors, especially subcontractors, were unaware of the

requirement to get the DBA insurance. What is the Department doing now to make sure they are aware of that requirement?

Mr. HARRIS. We are working with the contracting agencies. Let me just say, the Defense Department, the State Department, and USAID are right now working on trying to develop a comprehensive data base of contractors. One of the problems that we have had is that we don't know who all the contractors, subcontractors, and sub-subcontractors are. All of them are supposed to be insured. So we are working with them in trying to develop that data base.

But we are also working with them to try and get information out to the contractors and subcontractors. That is a very, very difficult task because often you have foreign subcontractors working for American contracting companies. Frankly, that has been one of the biggest challenges. There are contractors in this system that are not insured.

Mr. JORDAN. But I assume there is some kind of formal education process that takes place on the front end. How does it work?

Mr. HARRIS. That is a fair question. I am afraid I am not going to be able to give you an answer that I don't know. I will be able to get you more information about that, but I can't describe the way in which we educate contractors as they enter the system. But my staff will get you some more information about that.

Mr. JORDAN. Let me do a related question, then. DynCorp created what they refer to as the Civilian Police Employee Assistance Program which informs employees about preparations they need to make prior to going to Iraq and Afghanistan. Then, in the event of injury, CPEAP officials act as an intermediary between the insurance company and the employee. Is this a good idea, this kind of an approach? Do you think it is a good idea?

Mr. HARRIS. Where the employer provides an intermediary with the insurer? I don't know. I am not familiar with that program so I don't know how well it works. I think anything that gets insurers to respond more quickly and gets those benefits paid, the compensation and the medical benefits paid more quickly is a good idea.

But let me just say, I think that sort of tinkering around the edges is not going to work here. I think that we need to really look at fundamentally changing this program. The system is certainly not geared for the number of contractors that we have right now. When this program was created we were talking in the numbers of hundreds. Now we are talking in the thousands, 15,000 I believe in the last fiscal year. That is a lot of claims for a system that is not built to manage that quantity of claims. So individual programs here and there may benefit but as I said before, I think we need to look at fundamental reform.

Mr. JORDAN. Thank you, Mr. Chairman. Thank you.

Mr. KUCINICH. I thank the gentleman. The Chair recognizes Mr. Cummings of Maryland.

Mr. CUMMINGS. Mr. Harris, let me ask you this: You said there was limited competition. In other words, there were limited numbers of insurance companies doing this?

Mr. HARRIS. That is true. My understanding is that the three large insurance companies have about 90 percent of this market: AIG, CNA, and ACE. I believe that AIG has 80 percent of the De-

fense market. That is not very much competition. I believe the State Department has a sole source relationship with CNA.

Mr. CUMMINGS. OK. All right, let me tell you where I am going. Let me guide you to where I want you to go. They can't lose with these contracts, can they? They cannot lose. As I understand it, the way this DBA is structured, they cannot lose. In other words, insurance companies cannot lose. Am I right? They are going to get paid the big time.

Mr. HARRIS. I think that is right.

Mr. CUMMINGS. Then why is there limited competition? I don't understand that. Corporations usually operate based on profit. You are telling me that three companies, they cannot lose. So why is there limited competition? I am not knocking you; I am just curious.

Mr. HARRIS. I think that is an excellent question. I am not sure I am the right person to answer it. We were actually talking about this earlier today in preparation for the hearing. I think one part of it is that the barriers to entry into the market are pretty high. For example, AIG has a very extensive system of offices, and Arabic speaking folks in Kuwait and I believe in Iraq. In order to get started up in this market and to be able to compete in the market, I think it would cost a lot of money to get in. That may well be it. But I don't want to represent myself as an insurance market expert.

Mr. CUMMINGS. I understand, but you are going to have to do that. You are going to have to become an expert because you are sitting here telling us that you believe that reform is necessary. I do appreciate you saying that. Thank you for coming in here and not trying to snow us. But this is the key: If we are going to change this system, we need to change it soon.

In a few minutes some people are going to come up here and they are going to talk about their personal tragedies. The one thing that Chairman Kucinich will tell you is that one of the things that we try to do is get Government to work for the people. A commitment made is a commitment that has to be kept. It is part of our responsibility, when you come in here and tell us that something is wrong and needs to be corrected and then after you testify people who are victims of the system come up and tell us how they have been victimized, then if it is not changed we become a part of the conspiracy of failure and mediocrity.

So now the question becomes what is the timetable on all of these changes that you are talking about? You have been kind enough to come in here and tell us that things are wrong. But words don't put one dime in the pockets of these people who have suffered, whose families have suffered, and whose surviving loved ones are suffering. Can you give us some timetables so we are not doing this same thing next year at this time?

Mr. HARRIS. Well, let me say that I agree with everything you just said. I hope that we are not here next year talking about this. I hope we are here next year talking about how to implement a new program.

Mr. CUMMINGS. The urgency of now.

Mr. HARRIS. I agree with you completely. But let me also say the timing is up to you. Congress needs to reform this program. The

Labor Department can't do it. There are changes that we can make but the fundamental reform that is needed is up to you.

Mr. CUMMINGS. Good. So, you are the one who is in the Department. What do you think would be the most effective way for us to address what you have already seen in the Department? Will we have the support, if we do what you suggest, of this administration? After all, the President is probably going to have to sign whatever we do.

Mr. HARRIS. I don't want to represent that the President is going to sign whatever you do. But we need to have more discussion with the contracting agencies. We are dedicated to doing that quickly. We are going to get this report from the Defense Department next month. Congress dictated that they do it and they are doing it. Then we are going to hopefully come to you with a proposal.

I have tried to give you four ideas that you can begin working on immediately to try and assess how they match up with solving the problems that exist in this program. So I think we should get started with that discussion right away about how to get to a bill. But I must say, because we need to have some more discussion within the administration about which of these choices we want you to make, I want you to go ahead and get started.

We are going to come to you hopefully with an answer soon. But I can't tell you exactly when that is going to happen. Hopefully soon.

Mr. CUMMINGS. Do you think this profit margin of 40 percent is reasonable or do you think that is a bit high?

Mr. HARRIS. I am not an insurance regulator so I am not really in a position to say.

Mr. CUMMINGS. Thank you, Mr. Chairman.

Mr. KUCINICH. I thank the gentleman. The Chair recognizes Senator Sanders.

Senator SANDERS. Thank you, Mr. Chairman. As I understand it, and you tell me if I am wrong, somewhere between 80 and 90 percent of the business that KBR let out for insurance seemed to go to AIG. Does that sound right to you?

Mr. HARRIS. I don't know the specifics of KBR's business. I was speaking with Congressman Cummings about the market as a whole and the Defense Department market. But I can't speak to KBR.

Senator SANDERS. That is my understanding, that the overwhelming amount of business from KBR went to AIG. Picking up on Mr. Cummings's point, above and beyond the terrible treatment that people who have put their lives on the line to defend this country have received, it does seem to me at least a little bit strange that workers' compensation companies providing insurance in Iraq and Afghanistan have made underwriting profits of $600 million on some $1½ billion in premiums. I don't think you have to be an insurance expert to suggest that may be war profiteering. Does that sound right to you?

Mr. HARRIS. It sounds like a lot of money to me. Again, just getting back to the Labor Department's role here, we are not insurance regulators. That is not our role in this system. Congress didn't give us that authority, so I am just not in a position to say.

Senator SANDERS. We are playing with American taxpayers' dollars that in this case go from the taxpayers to the DOD, go from the DOD to KBR, and go from KBR to AIG. What I think the taxpayers and the Government of the United States expect is that when people in fact get hurt, they get justice. When they need medical help, when their families need death benefits, they get it and they get it in a prompt manner.

Now, in my view, and I don't want to get into a partisan argument but I think the Bush administration will go down in history as one of the most incompetent administrations. You guys are new on the job but I hope very much, picking up from what Congressman Cummings just said, it is important that we turn the page on this issue. It is important that you work with Congress to give us your ideas so that No. 1, we have a cost effective program and are not wasting billions of dollars, and No. 2, more importantly, that when people get hurt on the job representing the needs of the United States of America, they get prompt and just compensation. Does that sound fair enough?

Mr. HARRIS. I agree with you. Let me go a little further. You have my commitment that we are going to work with you to fix this program.

Senator SANDERS. Thank you very much.

Mr. KUCINICH. I thank Senator Sanders. The Chair recognizes the gentlelady from California, Congresswoman Watson.

Ms. WATSON OF CALIFORNIA. Thank you, Mr. Chairman, for holding this very significant hearing. I want to thank Mr. Harris for waiting all these hours while we played in the sandbox on the floor. I think it is very, very important that we hear from you, the Department of Labor.

We had no idea when this new administration group started that we would have this kind of unemployment. But a good friend of the people is now over there, Hilda Solis, and I know her staff will do an excellent job in trying to straighten this out.

According to data from the Labor Department and anecdotal evidence from Federal contractors working overseas, the workers' compensation system currently in place is characterized by a high denial rate. You probably talked about this before I came to the committee, but it is characterized by a high denial rate for those requesting compensation while the insurance providers have benefited from significantly higher profits than those typically earned by conventional workers' compensation insurers. This conflict is perpetuated by a seeming lack of comprehensive oversight of the system, and I hope that is something that we will try to iron out, with oversight duties fragmented between the Department of Labor, the Department of Defense, and the Department of Justice.

So what kind of communication has there been? I think you have only been there on the job 2 weeks?

Mr. HARRIS. About 3½ weeks, ma'am.

Ms. WATSON OF CALIFORNIA. About 3½ weeks. You have picked up a lot. So what kind of communication has there been between the Department of Labor and the Department of Defense to control the high premiums paid to insurance companies and to ensure Federal contractors are receiving adequate care?

Mr. HARRIS. We have been in discussion with the Defense Department about reforming this program and the study that they are undertaking.

The Labor Department has no authority over premiums in this system. That is determined by the contracting agency that establishes the contracting relationship with the employer and establishes the relationship with the insurer. So we have no mechanism by which we can control those costs or regulate those costs.

Ms. WATSON OF CALIFORNIA. But as long as you are talking to each other, I would hope that you would mention that this is a serious problem, that our committee has questioned it, and to expect more questions from us. Can you pass that on?

Mr. HARRIS. I will.

Ms. WATSON OF CALIFORNIA. Can you tell me why the Department of Labor only referred one case, and this is probably before you arrived, one case to the Department of Justice for prosecution of an insurance carrier knowingly making a false statement for the purpose of reducing or denying benefits to an injured contractor despite evidence that such instances have occurred on numerous occasions? If you have not been there long enough to know about this case, I wish you could get back to us and let us know what happened under the last administration to reduce the number of cases that would go for prosecution. With that I will yield back my time, Mr. Chairman.

Mr. KUCINICH. I thank the gentlelady. I want to thank Mr. Harris for his presence here. This committee is adamant about making sure that the Department of Labor reforms its position on these matters to make sure that those who were injured are able to receive the compensation that they are entitled to. The committee thanks you. We will be in touch with you.

At this time we are going to call the second panel. We are combining the second and the third panel. I would like everyone to come forward. While you are coming forward I would like to take this opportunity, just to move expeditiously to put the witnesses in place, while you are coming forward, I am going to read some of the biographies because we are going to keep moving this along.

I also want to take the opportunity to thank those from the media who are here for their patience in waiting, the reporters, the cameramen, the technicians, and the producers, and for your role in helping to communicate this hearing to the general public. So thank you very much for your presence.

While the panel is getting into place, I want to talk about who we are going to be hearing from.

Mr. Timothy Newman, welcome. He was a former civilian contractor in Iraq for DynCorp. In 2004 he joined the U.S. Department of State CivPol mission to Iraq as part of the Global War on Terror. He spent 15 months in greater Baghdad training the Iraqi police forces and protecting fellow mission officers until on September 2, 2005 he was severely injured by a roadside bomb. Mr. Newman lost his right leg and sustained several other major injuries. Upon returning home, he worked with DynCorp to develop a program to better care for injured contractors.

Mr. Kevin Smith is a former civilian contractor who worked as a truck driver for KBR in Iraq. Mr. Smith was severely injured

when his supply convoy was ambushed by insurgents outside Baghdad in 2004.

John Woodson is also a former truck driver for KBR in Iraq. Prior to going to Iraq he was a construction supervisor in Houston, TX working with cranes in the rigging industry. He also worked in aerospace, commercial, and petrochemical fields for 25 years. On October 28, 2004 John Woodson was hit by an IED, losing his leg and most of his eyesight.

Gary B. Pitts is an attorney who has been handling U.S. Department of Labor cases for the last 30 years. Since the war began 6 years ago, he has been representing more civilian contractors wounded, injured, or ill from the war zone than any other attorney in the country. He has had over 300 ongoing Defense Base Act cases at all times for the last 4 years from all parts of our country. He is the owner of Pitts and Mills in Houston, TX. He served in the Army National Guard for 12 years and was a Captain.

General George Fay is executive vice president of Worldwide Property and Claim of CNA. He is responsible for claims, strategies, and operations for CNA's Property and Casualty Operations worldwide. He is also a member of CNA's Operating Committee. Before joining CNA in July 2006, General Fay was executive vice president and chief services officer at the Chubb Corp. where he spent more than 30 years in claims, operations, and administration holding positions of increasing responsibility. He is also a retired Major General from the U.S. Army Reserves.

Kristian P. Moor is AIG's executive vice president and president of AIU Holdings, Inc. He is responsible for worldwide general insurance companies of AIU Holdings, Inc., a leading global property and casualty holding company. He is also an executive vice president of American International Group, Inc. Prior to the formation of AIU Holdings, Inc., Mr. Moor was president and chief executive officer of AIG's Property Casualty Group.

Finally, Charles R. Schader is going to be joining Mr. Moor for questions from Members. He is president of Worldwide Claims, American International Group. As president of AIG's Worldwide Claims operation, Mr. Schader has substantial experience in addressing claims under the Defense Base Act and War Hazards Compensation Act.

I would like all of the witnesses who are either going to be making a statement, answering questions, or both to rise. It is the policy of our Committee on Oversight and Government Reform to swear all witnesses in before they testify. I would ask that each of you raise your right hands.

[Witnesses sworn.]

Mr. KUCINICH. Let the record reflect that each of the witnesses answered in the affirmative. You may be seated.

As with the first panel, I ask that each witness give an oral summary of his testimony and to keep this summary under 5 minutes in duration. Your entire testimony will be included in the record of this hearing.

I would like to begin with Mr. Newman. Thank you very much for being here.

To those who are here as contractors and have served, I think it is appropriate on behalf of the subcommittee to also say thank you for serving the United States of America.

You may continue.

STATEMENTS OF TIMOTHY D. NEWMAN, FORMER CIVILIAN CONTRACTOR IN IRAQ; KEVIN SMITH, FORMER CIVILIAN CONTRACTOR IN IRAQ; JOHN WOODSON, FORMER CIVILIAN CONTRACTOR IN IRAQ; GARY PITTS, PITTS AND MILLS ATTORNEYS AT-LAW; MAJOR GENERAL GEORGE R. FAY, EXECUTIVE VICE PRESIDENT, WORLDWIDE PROPERTY AND CLAIM, CNA FINANCIAL; AND KRISTIAN P. MOOR, PRESIDENT, AIU HOLDINGS, INC.

STATEMENT OF TIMOTHY D. NEWMAN

Mr. NEWMAN. Thank you. My name is Timothy Newman. I was injured in Iraq in 2005 while working for DynCorp as a civilian contractor. Since my injury, I have personally endured the effects of an outdated Defense Base Act and also advocated for other injured contractors through their ordeals.

I grew up in Charleston, South Carolina. I joined the Marine Corps at 17 and became a South Carolina Police Officer at 22. After September 11th, I volunteered for the Civilian Policing Mission through DynCorp International with the State Department.

I landed in Iraq on July 4, 2004 and hit the ground running, literally. I served with the State Department training unit that worked to train the existing Iraqi forces. We traveled the BIAP highway several times per day and my unit actually moved over 3,000 passengers without any injuries until September 2, 2005.

Just after leaving our compound, my vehicle was hit by a roadside bomb. The blast completely blew through the driver section of my vehicle. My navigator and friend of 20 years, Leon Vince Kimbrell, was killed instantly. The shrapnel and the blast tore off my right leg, shattered my left leg, almost severed my left wrist, and sent shrapnel through my lungs, intestines, and chest. I was blown completely out of the vehicle and found myself with a useless body on a dirty Baghdad street. I dragged myself down the street until my team rescued me and delivered me to the Combat Surgical Hospital in the International Zone within 20 minutes of the attack.

I spent the next 22 days in a medically induced coma and woke up in the U.S. Military Hospital in Landshul, Germany. This is where my personal story with the DBA begins. My initial care was amazing and my treatment by CNA was good. I was appointed a local case manager who expedited my care and worked with the hospital. My care did not begin to fail until I left the hospital.

In February 2006 I was ready to start walking on a prosthetic leg. By October I was disillusioned with the absence and lack of communication by my former employer, DynCorp, so I wrote a letter to the CEO. In a few weeks I received a phone call inviting me to Texas to talk about my complaint. I went to Texas with a shiny new leg and met my former bosses. The meeting ended with a decision to start a program of employee care. I also left with a part time job to start the new program.

We made great headway in caring for our employees and started associations and programs to help them. We had far less success with our insurance carriers. The actions that we received from the insurance carriers and companies were simply lip service. Other than limited support for some of our programs, they did nothing to make the process easier on our side or theirs. It was typical double talk and empty promises. After 2 years of fighting, I left the program late last year.

In 2007, my treating physician recommended I get a Power Knee system, a true bionic leg that acts in place and supplements the muscles that I lost. The legal battle for this leg took over a year and a half and resulted in me getting the system 557 days after it was initially requested. The Administrative Law Judge that concluded the Power Knee was both reasonable and medically necessary found or CNA's experts, that "neither physicians have opined with any degree of certainty that the Power Knee prosthetic will not address the claimant's need" and that both "have little knowledge regarding the claimant's medical status and regular daily activities and have no firsthand knowledge of the Power Knee prosthetic."

In October 2008, 1 month after leaving Dyncorp, my biweekly compensation checks began arriving but were only half of what the amount should be. After weeks of no communication, CNA claimed that while I was employed by Dyncorp I was overpaid. So without warning or discussion, they cut my compensation to recoup their funds. Of course, their assumption of what I made was baseless. At the time they did not even have my pay records from Dyncorp. I suffered through financial hardships for no real reason. My legal counsel requested a hearing on this dispute. It is now June and our hearing is set for August, almost a full year after the problem started.

In the 3½ years since my injury, I have met and tried to help so many people who were damaged in our national defense. I have personally talked three friends out of suicide. Each of them suffered greatly from Post-Traumatic Stress Disorder but their biggest battle was the one they were having with their insurance carrier to get real care for their problems. I know of more than one friend that did take his own life.

I have helped and supported a friend facing double amputation for war injuries while the carrier said it was not medically necessary. I have helped a man who had an RPG go straight through him twice who was denied help, support, or communication from his insurance carrier. I have seen friends with blast related hearing loss be denied help and be forced to buy their own hearing aids while their cases went to court. I can continue on and on.

I am not an expert but I am a victim with common sense who has seen failures of our current system. In my experience, the single biggest cause of these failures is the insurance carriers' practice of seeking profit in every way possible from our fight for national survival instead of becoming part of the forces united against our enemies. When this act was written by Congress, they sought to provide an expedited workers' compensation system for war effort workers. Once the DBA carriers hijacked the system and saw it as a source of profit, the program was lost.

I would like to personally thank you for your interest in this issue. Thank you for your commitment to making a difference and your service to all of us. I am happy to answer your questions.

[The prepared statement of Mr. Newman follows:]

Statement

Of

Timothy D. Newman

Domestic Policy Subcommittee

Oversight and Government Reform Committee

"After Injury, the Battle Begins: Evaluating Workers' Compensation for Civilian Contractors in War Zones"

2154 Rayburn HOB

Thursday, June 18, 2009

2:00 p.m.

Sen. Elbert D. Thomas of Utah (1941) "When once total war, spherical war, global war or whatever one may choose to call it, is undertaken, the sooner we bring home to our people the fact that all are responsible for the war, *all might suffer by the war and therefore all should sustain the losses*, the better off we will be in a social and governmental way."

Statement, EXPANDED

Good afternoon my name is Timothy Newman and I was injured in Iraq in 2005 while working for DynCorp as a civilian contractor. Since my injury I have personally endured the effects of an outdated Defense Base Act ("DBA") and also advocated for other injured contractors through their ordeals.

I grew up in Charleston, South Carolina. I am the son of a first generation American Mother and a Father whose family immigrated to the U.S. in the 1700's. They instilled in me a sense of patriotism, family and of right and wrong. At age 17 I joined the Marine Corps and at 22 became a South Carolina Police Officer. I was a good Cop and devoted my later career to training other Cops to be their best. After September 11th I was moved to do more. Once my children were old enough to thrive without my daily input I volunteered for a Civilian Policing Mission through DynCorp International with the U.S. Department of State ("DoS"). I landed in Iraq on the fourth of July 2004 and hit the ground running, literally.

I served with the CPATT Training Unit that worked to train the existing Iraqi police forces and move them closer to civilized policing and the recognition of basic human rights. After several months the situation on the ground worsened and my skills were needed to transport our officers through Baghdad and the surrounding areas. We traveled the BIAP highway several times a day. My unit moved over 3,000 passengers without any injuries until September 2nd 2005.

On that date, just after departing our compound my vehicle was hit by a roadside IED. The blast blew completely through the driver section of the vehicle, my navigator and friend of 20 years Leon Vince Kimbrell was killed instantly.

The blast tore off my right leg, shattered my left leg, almost severed my left wrist, and sent shrapnel through my lung, intestines and chest. I was blown out of the vehicle. I dragged myself down the street and was rescued by my team who delivered me to the Combat Surgical Hospital in the International Zone within 20 minutes of the attack. I spent the next 22 days in a medically induced coma and woke up in the U.S. Military Hospital in Landshul, Germany.

This is where my personal story with the DBA began. Initially my treatment and care were amazing. My own personal heroes are the men and women of the hospitals where I stayed. They, along with my family gave me many reasons to live. Initially my treatment from DynCorp's DBA insurance carrier (C.N.A. Global) was also good. I was appointed a local Nurse Case Manager who expedited my care and worked with the hospital staff.

My care did not begin to fail until I left the hospital. In February, 2006 I was ready to start walking on a prosthetic leg. By October 2006, I was disillusioned with the absence of communication from my former employer. I had viewed DynCorp as I did my old Sherriff's Office back home and I expected a lot more from them. If I had been injured on duty in South Carolina my agency would have rallied to my aid. This was not happening with my corporate employer, so I wrote a letter to the CEO... In a few weeks I received a phone call inviting me to Texas to talk about my complaint. I went to Texas on my shiny new leg and met with my former bosses. The meeting concluded with the decision to start a new program of employee care within the Civpol Division of DynCorp and the offer of a part time job to start the program. The first year was a joy. Our organization worked with many brave men and women who returned from the war zones damaged and broken. We had the honor of caring for the families of the friends that did not make it home and we worked hard to streamline every process imaginable to assist our DBA insurance carrier in delivering the compensation and authorizing the services we had contracted for and expected.

Although we made great strides in caring for our fellow employees and creating associations and programs to help them, we had far less success with the insurance carrier. The actions taken on their part amounted to lip service.

Beyond limited support for some of our programs they did nothing to improve the claims process. Their consistent practice was double talk and empty promises.

During a two year period in this role, my confidence and hope began to wane. The commitment from DynCorp had faded and the programs and overall effort had become less of a priority for them. In August of 2008 I resigned from DynCorp hoping to bring change to the system by other means.

In 2007 my treating physician recommended that I get an Ossur "Power Knee" system. This is a true bionic leg system that acts in place of and supplements the muscle I lost through the traumatic amputation of my right leg. It has restored the physical endurance I lost after my injury

The legal battle for this prosthetic began in March of 2007 and took over a year and a half of hearings, quotes, denials, depositions, examinations, and stress.

Finally, on November 6th, 2008, 557 days after it was initially prescribed, I received my power knee system.

The Administrative Law Judge that concluded the power knee was both reasonable and medically necessary found that of CNA's experts, ". . . neither Dr. [ ] nor Mr. [ ] have opined with any degree of certainty that the Power Knee prosthetic will not address Claimant's needs . . . "and that both "Dr. [ ] and Mr. [ ] have little knowledge regarding the Claimant's medical status and regular daily activates and have no firsthand knowledge of the Power Knee prosthesis."

I believe this issue was litigated not because C.N.A. or their lawyers thought I didn't need this prosthetic but because they were concerned about being denied War Hazards reimbursement.

One of the factors that precipitated my resignation from DynCorp was a reduction in hours that prevented me from performing the duties that the position required.

C.N.A. was advised of the reduction in my earning which should have should have resulted in a corresponding increase in workers compensation benefits.

Without concluding their investigation of my actual earnings, in October of 2008, one month after my resignation from DynCorp my bi-weekly compensation checks from C.N.A. were substantially reduced. This action was allegedly justified by an overpayment of benefit. Although there is no dispute that even after my rehabilitation is concluded, at a minimum, I am entitled to 288 weeks of compensation for the loss of my limb and that I am entitled to compensation at the maximum rate, C.N.A. chose to reduce my compensation to a level that prevented me from paying my mortgage and my car payment. The point is this. Their actions served no purpose but to create a financial hardship.

These examples are typical of the administration of DBA claims. It is a system that failing many men and women who answered a call and risked their lives to be a part of the war on terror. In the 3 ½ years since my injury I have met and tried to help many people who were damaged in our national defense.

I have personally talked three friends out of suicide, each of them suffered greatly from PTSD but their biggest stressor was the battle they were having with their DBA insurance carriers to get care for their problems. I know of more than one friend that did take their life in despair.

I have helped and supported a friend facing amputation for war injuries while his DBA carrier argued that the amputations were not medically necessary. This 39 year old man was faced with two choices; (1) keep two useless feet and be bound to a wheelchair forever or (2) undergo amputation and flourish with two high tech prosthetic feet. That is not a choice for a man wanting to live his life rather than watch it pass him by.

I have helped a man who had an RPG go straight through him twice, who was denied help, support or simple communication from the DBA insurance company. I have seen friends with blast related hearing loss be denied any help and be forced to buy their own hearing aids while their case went to court.

I could continue on and on but instead I would rather discuss what could be done to make the DBA work.

I am not an expert but I am a victim with common sense who has seen the failures of the current system. In my experience the single biggest cause of these failures is the insurance carriers' practice of seeking to profit in every way possible from our fight for national survival instead of becoming part of the forces united against our enemies.

When this Act was written Congress sought to provide an expedited workers compensation structure for war effort workers, they purposely geared the system toward the injured worker with an eye toward making this a less litigious and more dispute oriented system. Once DBA carriers became primarily profit-driven the legislature's intent never stood a chance. .

Changing the law to discourage the rampant profiteering of the insurance companies is the only alternative to avoid the creation of a totally new care system changes might that erase the good parts of the DBA.

How do we change the DBA?

- Establish a mechanism that allows for the Office of Workers' Compensation Programs ("OWCP") to independently investigate the veracity of claims and recommend solutions to service related disputes with insurance carriers. Further train the OWCP hierarchy in dispute resolution and reinforce the goal of settling disputes at the informal level. Empower the OWCP to make recommendations binding on insurance providers. Preserve formal hearing structure as a remedy for disputes but include penalties for frivolous disputes that will encourage all parties to avoid the formal process in favor of resolution.
    - Standards of care should be set to provide for uniform treatment of injured workers. Provider disputes should be tracked and habitual or repetitive disputes or those previously adjudicated should be used by OWCP to persuade providers to avoid service problems or issues.

- The DBA should be reviewed by congress every five (5) years or within six (6) months of the initiation of hostile actions or humanitarian operations that will utilize substantial contractor service.
  This will allow for incident by incident amendment of the DBA if necessary so that service standards can adequately address the problems arising from a given conflict. For example: special training on claims for Post Traumatic Stress Disorder arising out of the Global War on Terror.
- Create a means of classifying claims as War Hazards and a mechanism for appeal by carrier's who are denied the designation. This will allow carriers a guaranty that their claims will be reimbursed and allow them to streamline their claims management.
- With the guarantee of reimbursement, claims will be limited to this rate and any excessive profiting should be investigated. Basically, insurance providers would relinquish the temptation of excessive profit for the standard profit, this will help to ensure that the system contains profit but discourages excesses and therefore benefits prompt care.
- Just as the DBA provides for generous compensation and treatment it is meant to discourage conflict. The cost of DBA claims and the injuries to workers underlying those claims are the price of being involved in global conflict. The profit regulation requirement would assure providers a set reimbursement (profit) rate which would act as an incentive to streamline and maximize the efficiency of the services. Providers would be discouraged from disputing all but the obviously invalid claims as often now do because they are perceived as potentially costly. Setting a profit standard and linking participation in the DBA coverage with profitable contracts in other government programs could improve the system. While not perfect the limitation of profits to 15% DBA claims administration will cost less and improve the efficiency of the system exponentially.
- Establishing penalties, limiting profits and putting in place the ability for contractor holders (the US Gov) to recoup Insurance profits above 15% we will establish a support system that will work rather than be a perpetual motion machine of victimization.

- Insurance providers would be required to deliver to the US DoL annually a DBA Profit Report and must show that their profits were limited to the set rate (15%) or why their profits exceeded that limit. Unwarranted excesses would result in a penalty that would reduce the profits below the set rates. Eventually, providers would self police themselves and understand that supporting our national missions are not profit potentials.

In closing, I am simply someone who has experienced the failures of the system and the behavior of the insurance companies who are paid to provide our care. The men and women who rely on this system were Cops, Soldiers, Truck Drivers, Cooks, Teachers, Construction Workers, Mothers, Fathers, Sons, Daughters and friends. They answered the call for many different reasons but they did answer the call and they were promised and expected to be cared for if the worst happened. War is Hell, these injured Heroes have seen it overseas and now they are seeing the Hell of America. Two things that I have experienced since my explosion have changed my life. First was seeing my dead friends two daughters Victoria and Caitlin grow into beautiful, smart and loving young women. The other was talking a friend out of suicide. This friend had seen and survived evil and horror of the war in Iraq only to fall into despair over the treatment he received when he came home. He and other men and women are just as much a part of our national defense structure as my two Marine Sons. They deserve the same acceptance, care and appreciation. They also deserve a system that does not fail them.

I would like to personally thank you for your interest in this issue, your commitment to making a difference and to your service to all of us.

In my 3 ½ years of recovery I have gained many friends who have shared their own ordeals with CNA and their frustration with the Defense Base Act. I have attached their stories and redacted any personal information. These people are a minute number of those victimized by a system focused on profit than care.

Contractor Care System & The Defense Base Act, Revision

Timothy D. Newman

Today, private contractors who include; professional American Police, Firefighters, Administrators, Cooks, Truck Drivers and individuals with a myriad of supporting skills that are essential to the success of an American military.

Our military cannot survive or thrive without the work of its civilian partners and their supportive establishment. Years ago our military streamlined its ranks to create a war fighter persona that focused on gradually reducing and often eliminating from its ranks the administrative and supportive skills and professions. Additionally our military has never possessed a staff of seasoned professionals who can provide infrastructure support for emerging and recovering countries to establish themselves and encourage democratic law and civil order.

Our contractor infrastructure has grown and shrunk with the ever-changing needs of our country. Not since the reconstruction of post WWII Japan has our task been as great as in the support of our Global War on Terror and in the reconstruction of Iraq and Afghanistan. The need for supportive and specialized professional skills has never been so vital. While the "private contractor" system of support and management has many shortcomings the system is essential to our national survival as is the aftercare of our returning contract veterans. Presently, all injured contractors rely on a private insurance system applied through a 60 year old law that was never intended to support their level of commitment or service. The current system is in my opinion plagued by greed while the Defense Base Act ("DBA") was at its inception designed to limit profiteering, legal wrangling and victimization. The issue is not one that the issue has been ignored like our military medical establishment or unforeseen as our national disaster response it is one that we have allowed the mega-providers to reconfigure the system into one that allows them to enlarge their profits to suit their own needs rather than to provide efficient and timely disability care to those who were promised it.

In 1941 Congress saw a need, acted and then abandoned their good intentions to money driven, privately controlled private giants who have pushed our national economy into a disaster.

In 2009, our national leaders must act to save the work of their predecessors and to save the health and safety of so many national heroes.

Presently military and defense contractors who serve as part of an overseas mission or conflict support are required by the DBA to have employer provided insurance should they become disabled, injured or are killed in the line of duty. The present regulations were written in 1942 and last revisited and amended in 1958. The regulations are on their face generous and well intended, but with the profit driven environment today the regulations are easily swamped and discounted by the legal wrangling of insurance providers, legal counsel and an overburdened regulatory system. The U.S. Department of Labor ("DoL") provides oversight and guidance for the employee, employer and the insurance providers as a subcontractor of the employer.

While the DoL Office of Workers' Compensation Programs is tasked with mediating coverage disputes between the carriers and the injured workers they do not possess the authority to force the carriers to provide treatment or compensation. I believe this practice only encourages the routine denial of claims, request for services and necessary medical treatment. Insurance providers concentrate on their profit margins rather than providing quality and necessary medical care as intended with the passage of the Defense Base Act. Insurance profits were and the removal of those incentives were a direct focus of the DBA when passed and legally linked and supported by the War Hazards Act which provides for total Federal reimbursement of all related cost plus a built in profit and administrative fee of 15%.

As intended the DBA should have streamlined the process and eliminated the focus of companies on profit by providing them an automatic profit rate. The injured workers who are already victims and are suffering medical and emotional stress must contend with the added victimization of the legal process.

Men and women who survived the nations Global War on Terror have taken their own lives in desperation fighting the invisible enemies who are supposed to be their support system. How can this system be fixed and how can these brave Americans receive the proper care and a level of concern that attempted to match their sacrifice?

There are two options left; a total restructuring of the contractor support system which would equate the socialization of their care or a revisiting of the DBA which would redefine the scope of the program. The powers of the DoL require providers to act and the revision of the legal system that must be the backbone of the entire system.

The DBA should be focused on providing support to injured workers. Retaining a standardized profit rate and prohibiting the lure of profiteering would greatly streamline the system, by removing the temptation of swelling their profit insurance providers would dispute far less claims and limit their disputes to the more valid issues. Including a penalty system that would punish insurance providers for disputing normally accepted claims would change the system and streamline the legal process instantly. Including in the statute a provision for Administrative Law Judges ("ALJ") to penalize providers for pursuing frivolous disputes would ensure that providers gave up an attitude of denying without cause and again make the legal process far more effective and far less costly. Additionally, the inclusion of language that requires proof of DBA coverage for any contractor's entry into a conflict zone or to obtain the necessary military identification would greatly limit the possibility that uninsured contractors would operate in conflict zones. Standardized contractor education in DBA coverage requirements should also be required for employers to be awarded government contracts at covered locations.

The DBA should retain the elements that allow employees to select physicians and supportive care providers; this would ensure that cost are minimized and that the Act retains its efficiency and positive points. Simply fixing the minor problems with the DBA would be far easier than creating a new system of claims administration.

The number of contractors needing DBA benefits changes with the environment of the world. Making the shortsighted choice of throwing money at the problem and building a VA system, as some have suggested, that will only be ignored when conflicts end and where funding could be easily refocused as with the conditions of Walter Reed will result in another crisis in our children's future. By enhancing a legally backed, professionally overseen, properly motivated administration we can provide a support system that will grow and shrink with the changing needs of the country.

These men and women will need this support, current and future contractors deserve a supportive system and we all agree that they deserve to be treated with the respect and concern we care for all our national servants and heroes. We have let these men and women down. The legacy of these men and women who answered the call at our generation's most trying time could very well be the guarantee that those who follow in their footsteps will never be discarded and should not be the broken care and compensation system.

The solutions to our present crisis with the application of DBA can be resolved with the revision or restructuring of the Act that includes the following:

- Establish the US Department of Labor ("DoL") as a true management entity, establish a method or system within the DoL to independently investigate, consider and recommend the solutions to service related disputes with service providers. Set a legal standard of service, train the DoL hierarchy in dispute management and set a goal of settling disputes within the DoL system. Assume that many issues will be settled on behalf of the injured party as demonstrated in the years of dispute settlements and empower the DoL to make these binding recommendations to insurance providers. Maintain the formal (ALJ) remedy for disputes but include penalties for frivolous disputes that will actually encourage the providers to avoid the formal legal processes.
    - A DoL, DBA Management System that makes legal recommendations that should be followed.

Continued disputes can be appealed to the ALJ with automatic penalties for unwarranted disputes or frivolous conflicts.

- Service standards should be set to allow for the uniform care of injured employees and services. As disputes are settled and conflicts are resolved service standards should be set to avoid future disputes. Provider disputes should be tracked and habitual disputes or disputes that have previously been adjudicated should be used to persuade providers to avoid service problems or issues.

- Government contract employers should be required to standardize the pre-deployment DBA briefings they provide employees prior to deployment. The DoL should govern the content of these briefings with updated information and materials. The DoD should require evidence of this training before the issue of any authorization to enter a combat zone or issue of any identification cards.
- The DoL & DoD should require that every report of injury be officially investigated close in time to the occurrence. Too many injuries are sustained without any real documentation other than the initial report of injury supplied to the insurance carrier. In the case of death, serious injury, emergency evacuation or critical incidents (with mass injury potential) the DoD, DoS or DoL should conduct an incident investigation that will seek justice, document all potential casualties and serve as reference for future inquiries. Regardless of any other reported injury this record would be maintained by the employer, insurance carrier and contracting government agency for future reference. This would act as supportive documentation for cumulative injuries, PTSD claims and similar claims by injured workers.
- The DBA should be reviewed by congress every five (5) years or within six (6) months of the initiation of hostile actions or humanitarian operations that will utilize substantial contractor service. This will allow the incident by incident application of the DBA, service standards could not be reduced or service prohibited but situation specific issues addressed and specialized inclusions added.

For instance, the special inclusion of the treatment of Post Traumatic Stress Disorder applied as demonstrated during the Global War on Terror.

- Provide for an Initial Status Legal Process or finding that will quickly designate claims as War Hazard claims along with an appeals process for disputes. The setting of claim standards that will define what claims are War Hazard claims and what are Non-War Hazard claims. This will allow providers the forehand knowledge that a claim will be reimbursed and allow them to streamline their standard claim management.
- The system should include an appeals system that will allow employers, employees or legal counsel the ability to appeal War Hazard designation they feel improper. Additionally, receiving the War Hazard designation would standardize policy profits to the legal administrative and management percentage. With the guaranteed profit reimbursement claims will be limited to this rate and excessive profit investigated. Basically, insurance providers would relinquish the excessive profits for the standard profit which will ensure that the system contains profit but discourages excesses and therefore benefit issues. Just as the DBA provides generous services and coverage it discourages conflict related suits that are basically the price of being involved in that type of world politics. This requirement would assure providers a set reimbursement (profit) rate which would act as an incentive to streamlines and maximize the efficiency of the services. Providers would be discouraged from disputing all but the obviously disputable claims in return for a guarantee of recovery.
- Set a profit standard and link participation in DBA coverage with profitable contracts in other government programs and limit private profits to the set 15%. While not perfect the limitation of profits to 15% as set by the original DBA will reduce the disputes, improve service, cost less and will improve the efficiency of the program exponentially. Establishing penalties, limiting profits and putting in place the ability for contractor holders (the US Gov) to recoup Insurance profits above 15% we will establish a support system that will work rather than be a perpetual motion machine of victimization.

  - Insurance providers would be required to deliver to the DoL annually a DBA Profit Report and show that their profits were limited to the set rate (15%) or why their profits exceeded that limit. Unwarranted excesses would result in a penalty that would reduce the profits below the set rates. Eventually, providers would self police and understand that supporting our national missions are not profit potentials.

- Regarding the treatment of injuries that are largely unique to military and defense contractors the legal allowance for contractors to obtain and be admitted at designated government specialized centers should be made. The DBA should include a provision to fund or reimburse these centers for treatment which would have not have been possible as part of their operational budgets. This would make specialized treatment available to contractors and avoid the creation of mirror facilities in the public sector that will hopefully outlive their usefulness as conflicts end. This would also serve to continue to group military and defense veterans together and expedite their recovery. Some of these facilities that could be utilized as available could be the:
  - Traumatic Brain Injury Center
  - The Post Traumatic Stress Disorder Center
  - VA Amputee Center and Local Clinics
- Additionally, many contractors are former military veteran or performed duties in the war zones that essentially made them active partners with the military units they were assigned to. These specialized contractors performed exactly as the military until their specialized skills were needed, these included; Military and Police Trainers, Corrections Trainers, Judicial Trainers, Technical Contractors, Project Protection Specialist and Security Detail Specialist. The veterans fraternity is growing daily and so is the number of associated contractors, along with this increase is the increase of injured contractors who would benefit from belonging to the same fraternity or social group outreach program. Many of these outreach programs are limited to military only and receive funding along those lines.

Some provision should be made to provide funding to these groups in return for inclusion of specific contractor categories. This would provide these contractors who had been so entrenched in the military establishment to continue this relationship and not be alienated simply because of label. This designation could be required at the onset of certain military contracts with employers being required to pay some memberships, provide supportive funding or the like based on requirements of designated contracts.

For instance, Electricians working to maintain an electrical system on a military base within the war zone that only provide a support function would not fall into this category, Contract Intelligence Officers who operate alongside their military units on a daily basis and who provide additional capability to these units would be eligible for this program and would be able to avail themselves of typical military support programs post-conflict. This contractor's employer would be required to provide limited support or funding to these programs through some type of unified contribution system. Again, one of the biggest stressors or contributors to PTSD is the feeling of abandonment once at home, the availability of these programs to the contractor and the brotherhood and support they provide would help greatly.

- There are presently several government programs intended to assist or reimburse victims in certain situations. These programs should be researched by the DoL and catalogued for reference and to expedite victim's claims. For instance, the U.S. Department of Justice ("DoJ") has a program to provide reimbursement for the victims of terrorism (ITVERP) but employees who make claims under this program face long delays, red-tape and communication issues. Presently, claims under this program regularly take one to two years before any decision. The DoJ penalizes victims who lack documentation of the incident when the employer, contracting agency or military failed to document the attack or investigate the incident.

Being a non-combatant employed overseas should not prohibit them from being part of this program and the lack of professional action or documentation should not be viewed as the fault of the injured person.

- Many contractors are called upon to perform professional training or oversight that the military cannot and intend to return to their careers after serving as part of the overseas mission. For instance, American law enforcement officers are encouraged to join the law enforcement training mission to re-establish the infrastructures of these nations. The mission requires that they are trained and certified in law enforcement and presently officers relinquish those certifications to be part of these missions.
    - The contracting government agency and the DoJ should work to create a system where these types of contractor can retain their required training and certification throughout their missions. This will ensure that mission officers are able to more easily return to their communities and encourage their communities to work within the system and not discourage participation. Ultimately this will improve the quality of the mission officers and not cause the professionals to suffer. Some type of required training and certification should be offered and required of employers and state regulations should be lobbied to allow these programs to succeed.
    - With these types of programs in place many contractors will then be eligible for programs designed to benefit their professions. For instance, it is undecided if law enforcement officers qualify for the US DoJ Police Officers Survival Benefits Program (PSOB) which provides the families of slain American police officers certain benefits such as education benefits, counseling programs, memorialization and acceptance in the brotherhood of professional career law enforcement heroes. These brave men and women should not be penalized for volunteering to take the fight against terror to the enemy's backyard rather than remaining in their own backyards.

Over 30 career professional law enforcement heroes have died overseas as part of DoS & DoD missions and do not qualify for DoJ benefits or recognition on the National Law Enforcement Officers Memorial Wall in Washington, DC. The children of these heroes do not receive the same acceptance and benefits that other children of slain officers do. This only serves to further victimize these families and discourage others from participating in these types of programs that are essential to our nation's future success and safety.

Mr. KUCINICH. Thank you, Mr. Newman. Mr. Smith, you may proceed. I would ask that you hold the mic close enough so we can hear your testimony. Thank you, sir.

STATEMENT OF KEVIN SMITH

Mr. SMITH. Thank you, Mr. Chairman. Gentlemen and women of the committee, I appreciate you all having me here today. This has been a long time coming and I am proud to be here.

My experience with AIG has been traumatic at best. I thought everything was fine at first. Then, as I needed more treatment, things began to get tougher. I couldn't get treatments my doctor recommended like medication and sleep studies so I did without or I paid for myself. This has greatly hindered my continuity of care, thereby increasing the time it has taken me to achieve the goals dictated by my medical providers.

The trauma associated with the PTSD is nothing, I mean nothing, compared to the trauma myself and my family has had to cope with because of AIG's blatant incompetence and egregious behavior.

In two separate instances AIG has stopped paying my indemnity. The first time was in November 2005 and then again in November 2007. In November 2005, the benefits were reinstated but it took several months before I started receiving my checks again. Then I had to fight to get the checks I had missed.

I started investigating and was alarmed to find out that my doctor had not been paid for procedures or office visits from 2004. Although AIG would approve the treatment, they would not pay. So the doctor that saved my leg and possibly my life was considering not treating me any longer.

In November 2007, AIG completely stopped paying all benefits, including medical, that I am supposed to receive for life according to the DBA. They refused to pay for another surgery needed on my knee or any other doctor's care. They would not even pay for medication I was taking for the PTSD. Basically, they completely ignored the fact that I had been diagnosed with PTSD as a result of my experience in Iraq. They have used some of the most ridiculous excuses trying to defend their position. To top it all off, they tried to say they had overpaid me by $23,406.60.

I had to endure a long, grueling battle to reinstate the benefits that should have never been stopped. During this time, my family and I still had to live so I was forced to return to work in a job that exacerbated my injuries to my leg and the PTSD.

They stopped benefits based solely on the fact that the schedule on my leg was paid out without considering that I was still being seen by a psychologist which, I might add, they approved. They obviously knew they had no legal grounds to drop me but I guess that is part of the game they play in order to wear people down so they will no longer have the will to fight.

My attorney put in a request for an informal hearing with the DOL, the Department of Labor, which was denied. We appealed that and got our hearing in which the hearing officer found in favor of me and ordered that the benefits be reinstated. But in AIG's normal fashion, they acted with impunity and continued to deny benefits.

We then requested a formal hearing with an Administrative Law Judge and were heard on July 30, 2007. Judge C. Richard Avery found that I should in fact receive all benefits and back pay with interest plus all out of pocket expenses and that all the doctors be paid. AIG has still failed to comply with this order entirely. They have not called and approved my treatment for PTSD. They have denied payment for medications. They have just now made a partial payment to my doctor for services rendered back in 2004. I want to point out the partial payments, ladies and gentlemen. They only paid less than half in most cases and never, I repeat never, have they paid in full.

In summary, I have provided this committee with facts that I have backed up with evidence of AIG's downright criminal handling of cases of American men and women who put their lives in peril for this great country. All personnel serving in a hostile foreign land must be taken care of when they return home, whether they served in the military or as a civilian contractor. We did what most people would not do. Therefore, we should all be considered by our country as the heroes we are. A large portion of the contractors, like myself, were veterans of numerous hostile engagements and volunteered to go to Iraq for the chance to once again serve their country. We demand that we receive the care that was promised us and that we deserve.

Listen, we are not asking for millions of dollars in bonuses. We are not asking for lavish parties or even parades. We want what we are entitled to under the Defense Base Act like medical care, disability pay, and retraining if necessary.

Thank you.

[The prepared statement of Mr. Smith follows:]

Statement
Of
Kevin Smith
Former Civilian Contractor Injured in the War Zone

Domestic Policy Subcommittee
Oversight and Government Reform Committee

"After Injury, the Battle Begins: Evaluating Workers' Compensation for Civilian Contractors in War Zones"

2154 Rayburn HOB
Thursday, June 18, 2009
2:00 p.m.

My experience with AIG has been traumatic at best. I thought everything was fine at first, then, as I needed more treatment, things began to get tougher. I couldn't get the treatments my Dr's recommended like medication and sleep studies so I did without or paid for them myself, which has greatly hindered my continuity of care, thereby increasing the time it has taken me to achieve goals dictated by medical providers. And the trauma associated with PTSD is nothing compared to the trauma myself and my family has had to cope with because of AIG's blatant incompetence and egregious behavior.

In two separate instances AIG had stopped paying my indemnity. The first time was November of 05 and then again in November of 07. In November 05, the benefits were reinstated but it took several months before I started receiving checks again. Then I had to fight to get the checks I missed. I started investigating and was alarmed to find out my Dr's had not been paid for procedures and office visits from 04. Although AIG would approve treatment, they would not pay, so, the Dr's that had saved my leg and possibly my life was considering not treating me any longer! *(See attachment A)*

In November 07 AIG completely stopped all benefits including medical that I am suppose to receive for life according to the DBA. *(See attachment*

B) They refused to pay for another surgery needed on my knee or any other Dr.'s care. They would not even pay for medication I was taking for PTSD. Basically they completely ignored the fact that I had been diagnosed with PTSD as a result of my experience in Iraq, and they have used some of the most ridiculous excuses trying to defend their position. And to top it all off they tried to say they had overpaid me by $23,406.60! *(See attachment C)*

I had to endure a long and grueling legal battle to reinstate the benefits that should have never been stopped. During this time, my family and I still had to live, so I was forced to return to work in a job that exacerbated injuries to my leg and PTSD. They stopped benefits based solely on the fact that the schedule on my leg was paid out without considering I was still being seen by a psychologist, which I might add, they approved. They obviously knew they had no legal grounds to drop me but that's part of the game they play in order to wear people down so they no longer have the will to fight.

My attorney put in a request for an informal hearing with the DOL which was denied. *(See attachment D)* We appealed that and got our hearing in which the hearing officer found in favor of me and ordered that benefits be reinstated. (*See attachment E)* But in AIG's normal fashion they acted with impunity and continued to deny benefits. We then requested a formal hearing with an Administrative Law Judge and were heard on 30 July o7. Judge C. Richard Avery found that I should in fact receive all benefits and back pay with interest, plus all out of pocked expenses and that all Dr's be paid. *(See attachment F)*

AIG has still failed to comply with this order entirely. They have not called and approved my treatment for PTSD. They have denied payment for medications. They have just now made partial payment to my Dr. for services rendered in 04. I want to point out the partial payments. They have paid well less than half in some cases and never in full. Also they have tried to dictate medical care which is illegal. *(See attachment G)*

In summary I have provided this committee with facts backed up with evidence of AIG's downright criminal handling of cases of American men and women who put their lives in peril for this Great Country. All personnel serving in a hostile, foreign land must be taken care of when they return home whether they served in the military or as civilian contractors because we all did what most people would not do, therefore we all should be

considered by our country as the heroes we are. A large portion of the contractors, like myself, were Veterans of numerous hostile engagements and volunteered to go to Iraq for the chance to once again serve their Country and we demand that we receive the care that was promised us and we deserve. We are not asking for million dollar bonus, or lavish parties or even parades, we just want what we are entitled to under the Defense Base Act like medical care, disability pay and retraining if necessary.

ORTHOPEDIC SURGERY
L. Shannon Holloway, M.D.
Shannon E. Cooke, M.D.
David M. Stark, M.D.

Abilene Bone & Joint Clinic, L.L.P

1749 Pine
Abilene, Texas 79601
(325) 672-4372
FAX (325) 673-0856
Web page: www.bonejointclinic.com

March 31, 3006

AIG World Source
Attn: Kathy Griffin
8144 Walnut Hill Lane, Ste. 1700
Dallas, TX 75231

Re: Kevin Smith-Idol
CL # D900299

Dear Ms. Griffin:

This letter is to bring to your attention that payment for services rendered to Mr. Smith beginning on December 7, 2004 through March 23, 2005 have not been paid. We have filed these claims and made several attempts for payment but to no avail. We spoke with Review Med and were given dates and amounts that was sent to AIG for the recommended payment, but we have not received payment for the above dates of service. The outstanding balance at this time is $4,220.00.

We have no other alternative but to discontinue treating Mr. Smith until this matter with the insurance company is settled.

Your assistance in this matter would be greatly appreciated.

Sincerely,

Shannon E. Cooke MD

Shannon E. Cooke, MD
Abilene Bone & Joint Clinic

cc: Toby Cole
Attorney

Joe C. Hubbard, MD
P.O. Box 1680
Abilene, TX 79601

TO WHOM IT MAY CONCERN

RE: Smith, Kevin
D900330046
DOB: 6/201969

I do the collections on outstanding accounts for Dr. Joe Hubbard. In working the above referenced account, I did note that there was a note attached which states...

"FED WK COMP WILL NO LONGER PAY CLAIMS. PATIENT WILL BE RESPONSIBLE FOR ALL MEDICAL CHARGES KT PER LINDA WEBB AIG 214-932-2127 KT 2-8-08"

Cindy Carter

Cindy Carter
325-668-4993

AIG **AIG WorldSource**
A Division of American International Companies®

November 7, 2007

Midani, Hinkle, & Cole, L.L.P.
Tobias A. Cole, Attorney
10497 Town and Country Way
Suite 530
Houston, Texas 77024

RE:	Claim Number	: D900-30046
	Insured	: Brown & Root/SEII
	Claimant	: Kevin Smith
	Date of Loss	: 04/08/2004

Dear Mr. Cole:

Enclosed, please find the LS208. The PPD has been paid in full with an overpayment of $23,406.60. The indemnity payments have ended as of 10/26/07. The claimant was paid thru 11/01/07.

If you have any questions, please let us know.

Very truly yours,

Linda Webb
Claims Examiner
Tel: (214) 932-2430
Fax: (214) 932-2127
E-Mail: linda.webb@aig.com

✓ CC: Kevin Smith
3117 Melinda Lane
Abilene, Texas 79603

C [redacted]

RECD JAN 3 0 2007

U.S. DEPARTMENT OF LABOR

EMPLOYMENT STANDARDS ADMINISTRATION
Office of Workers' Compensation Programs
Division of Longshore & Harbor Workers' Compensation
8866 Gulf Freeway, Suite 140
Houston, TX 77017-6528

28 January 2008

OWCP#: 02-135637
Claimant: Kevin Smith-Idol
Employer: Brown & Root/SEII
DOI: 04-08-2004

Midani, Hinkle & Cole, LLP
Attn: Tobias Cole
10497 Town & Country Way, Suite 530
Houston, TX 77024-1117

Dear Mr. Cole:

Your 15 January 2008 letter requesting an informal conference because claimant's benefits were terminated is acknowledged.

A review of the file shows that claimant was paid TTD benefits(see enclosed LS-208 dated 11/06/2007)from 04/09/2007 through 09/02/2005(when he was found to have reached maximum medical improvement(MMI)by Wright Singleton, MD. A functional capacity evaluation for done 09/09/2005 indicating that claimant was capable of returning to work in a light-heavy capacity or return to work full duty.

In a subsequent report dated 09/28/2005, Dr. Singleton indicated that claimant had 26% permanent partial disability(PPD) of the left lower extremity(LLE), thus, entitling him to a schedule award for 26% PPD LLE of $50,076.75(288 wks x 26% x $668.76), which insurance carrier commenced paying 09/03/2005 & continued paying until 11/01/2007. The insurance carrier has now claimed an overpayment of $23,406.60 which they are presently & are entitled to recoup.

If you disagree with this assessment, please provide your explanation along with any supporting documentation to this office within 20 days (by 19 February 2008) of the date of this letter.

At present, your request for an informal conference is denied.

Sincerely,

Freddy Conley

FREDDY CONLEY
Claims Examiner

FC/

Memorandum of Telephonic Informal Conference
(Under the Longshore and Harbor Workers' Compensation Act)

U.S. DEPARTMENT OF LABOR
Employment Standards Administration

Kevin C. Smith-Idol
Claimant

02-135637
2. OWCP File Number

Brown & Root/SEII
3. Employer

4. Carrier/Employer's Number

American International Underwriters
5. Insurance Carrier

03-21-2008
6. Date of Conference (M/D/Y)

04-08-2004
7. Date of Injury (M/D/Y)

8. Appearances:
_____Claimant present X Claimant not present

For the Claimant:
Tobias Cole

For Employer/Carrier:
Limor Ben-Maier

Issues: Temporary Total Disability(TTD)

9. ~~The claimant sustained/allegas an accidental injury on the date in item 7 while working~~ for the above-named employer, under the circumstances bringing the injury within the purview of the LHWC Act (33 USC 901 et seq.) or an extension thereof, resulting in the following injury(ies):

Gunshot Wound Left Femur
PTSD

Present claim: Claimant's attorney indicated that claimant still disabled per Dr. Sam Brinkman as a result of his PTSD; claimant TTD from 11/2007 & continuing.

11. Employer/carrier's position: Defense counsel indicated that claimant had been paid all TTD & 26% PPD schedule award; benefits were suspended 11/2007 because claimant refused to attend employer's IME exam; no recent medical reports from either Brinkman or Cooke; requests that claimant's attorney provide medical reports from both doctors; employer would like to have claimant's examined by Dr. Moller.

Upon discussion of the issues involved among the parties present, together with due consideration to all information in the administrative file, the following recommendation(s) is made:

RECOMMENDATION

This office recommends that claimant's attorney immediately provide this office as well as employer/carrier with all medical records of Drs. Brinkman & Cooke. In addition claimant & his attorney are to cooperate with & show up for employer's with Dr. Moller

TTD: This office recommends that employer/carrier reinstate claimant's TTD benefits from 11/01/2007 to the present & continuing plus interest at 1.52 percent through the date of employer's IME with Dr. Moller or the receipt of additional medical reports from Dr. Brinkman indicating that claimant is no longer TTD.

Freddy Conley
EDDY CONLEY
Claims Examiner

03-21-2008
(Date this Memorandum Issued)
LS-280s

cc: Midani, Hinkle & Cole, LLP
Attn: Tobias Cole
10497 Town & Country Way, Suite 530
Houston, TX 77024-1117

Kevin Smith-Idol
3317 Melinda Lane
Abilene, TX 79603

Wilson, Elser, Moskowitz, Edelman & Dicker LLP
Attn: Limor Ben-Maier
5847 San Felipe, Suite 2300
Houston, TX 77057

American International Underwriters
8144 Walnut Hill Lane, Suite 1700
Dallas, TX 75231

E[redacted]

RECD DEC 0 8 2008

U.S. DEPARTMENT OF LABOR

EMPLOYMENT STANDARDS ADMINISTRATION
Office of Workers' Compensation Programs
Division of Longshore & Harbor Workers' Compensation
8866 Gulf Freeway, Suite 140
Houston, TX 77017-6528

December 4, 2008

File Number: 02-135637
Injured Employee: Kevin C Smith-Idol
Date of Injury: 04/08/2004
Employer: Service Employers International

Gentlemen:

The enclosed Decision and Order of the Administrative Law Judge is hereby served upon the parties to whom this letter is addressed. The decision was based on all of the evidence of record, including testimony taken at formal hearing, and on the assumption that all available evidence has been submitted.

The transcript, pleadings, and compensation order have been dated and filed in the District Director's Office. Procedures for appealing are described on Page 2 of this letter.

The employer/insurance carrier is hereby advised that if the order awards compensation benefits, the filing of an appeal does not relieve that party of the obligation of paying compensation as directed in this order. The employer/insurance carrier is also advised that the additional 20 percent compensation under Section 33 USC Section 914(f)is not withstanding the filing of an appeal, unless an order staying payments has been issued by the Benefits Review Board, U. S. Department of Labor, Attn: Clerk of the Board, 200 Constitution Ave. N. W., Room S-5220, P. O. Box 37601, Washington, D.C. 20013-7601.

Sincerely

BRADLEY T. SOSHEA
District Director
bh
Enclosure

Page [redacted]

U.S Department of Labor

Office of Administrative Law Judges
St. Tammany Courthouse Annex
428 E. Boston Street, 1st Floor
Covington, LA 70433-2846

985-809-5173
985-893-7351 (FAX)

MEMORANDUM FOR: **Houston District Director**
Houston, TX

FROM: **C. Richard Avery**
Administrative Law Judge

SUBJECT: **SMITH-IDOL KEVIN C. v. SERVICE EMPLOYERS INTERNATIONAL**
Case No. 2008LDA00258, OWCP No. 02-135637

In accordance with the Regulations implementing the Defense Base Act, I am transmitting herewith my signed document this 2nd day of December, 2008.

Six (6) days from today, this Decision and Order will be posted on our website (www.oalj.dol.gov); however, under the Act and regulations such posting will NOT constitute official service, which is to be effected by your office.

FORWARDED:

Ellen C. Ales
ELLEN ALES
LEGAL ASSISTANT

Enclosure

cc: Clm Atty (w/o encl)
Emp Atty (w/o encl)
Sol (w/o encl)

***THE OFFICE OF ADMINISTRATIVE LAW JUDGES SHOULD NOT BE CONTACTED REGARDING SERVICE OF THE ABOVE DOCUMENT.**

F[redacted]

File Number: 02-135637
Date: December 4, 2008

A petition for reconsideration of a decision and order must be filed with the Office of the Administrative Law Judge, Who issued the attached decision and order, within 10 days from the date the District Director files the decision and order in his/her office.

Any notice of appeal shall be sent by mail or otherwise presented to the Clerk of the Benefits Review Board in Washington, D.C., within 30 days from the date upon which the decision and order has been filed in the Office of the District Director, or within 30 days from the date final action is taken on a timely-filed petition for reconsideration. If a timely notice of appeal is filed by a party, any other party may initiate cross-appeal or protective appeal by filing a notice of appeal within 14 days of the date on which the first notice of appeal was filed or within the 30 day period described above, whichever period last expires. A copy shall be served upon the District Director and on all other parties by the party who files a notice of appeal. Proof of Service shall be included with the notice of appeal.

The date compensation is due is the date the District Director files the decision and order in his/her office.

U.S Department of Labor

Office of Administrative Law Judges
St. Tammany Courthouse Annex
428 E. Boston Street, 1st Floor
Covington, LA 70433-2846

985-809-5173
985-893-7351 (FAX)

MEMORANDUM FOR:	**Houston District Director** Houston, TX
FROM:	**C. Richard Avery** **Administrative Law Judge**
SUBJECT:	**SMITH-IDOL KEVIN C. v. SERVICE EMPLOYERS INTERNATIONAL** Case No. 2008LDA00258, OWCP No. 02-135637

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FORWARDED:

Ellen C. Ales
ELLEN ALES
LEGAL ASSISTANT

Enclosure

cc: Clm Atty (w/o encl)
Emp Atty (w/o encl)
Sol (w/o encl)

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Issue Date: 02 December 2008

CASE NO.: 2008-LDA-258

OWCP NO.: 02-135637

IN THE MATTER OF

K. S.[1],
Claimant

v.

SERVICE EMPLOYEES INTERNATIONAL,
Employer

and

INSURANCE COMPANY OF THE STATE OF PENNSYLVANIA,
Carrier

APPEARANCES:

TOBIAS A. COLE, ESQ.
On behalf of Claimant

JOHN L. SCHOUEST, ESQ.
On behalf of Employer/Carrier

BEFORE: C. RICHARD AVERY
Administrative Law Judge

[1] Pursuant to a policy decision of the Department of Labor, the Claimant's initials rather than full name are used to limit the impact of the Internet posting of agency adjudicatory decisions for benefit claim programs.

DECISION AND ORDER

This is a claim for benefits under the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. 901 et. seq., (The Act), brought by Claimant against Service Employees International (Employer), and Insurance Company of the State of Pennsylvania (Carrier). The formal hearing was conducted in Houston, Texas on July 30, 2008. Each party was represented by counsel, and each presented documentary evidence, examined and cross examined the witnesses, and made oral and written arguments.[2] The following exhibits were received into evidence: Joint Exhibit 1, Claimant's Exhibits 1-14 and Employer's Exhibits 1-12. This decision is based on the entire record.[3]

Stipulations

Prior to the hearing, the parties entered into joint stipulations of facts and issues which were submitted as follows:

1. Claimant injured his leg on April 8, 2004 in the course and scope of his employment with Employer;
2. Employer was advised of the leg injury on April 8, 2004;
3. Notice of Controversion was filed on March 21, 2008; and
4. An Informal Conference was held on March 21, 2008. (JX-1).

Issues

The unresolved issues in this proceeding are:

1. Causation of Claimant's Post-Traumatic Stress Disorder (PTSD);
2. Nature and Extent;
3. Claimant's Average Weekly Wage (AWW) at the time of his injury; and
4. Claimant's entitlement to Section 7 Medical Benefits. (JX-1).

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[2] The parties were granted time post hearing to file briefs. Claimant's brief was submitted past the agreed-upon deadline, along with a Post-Hearing Motion to Add Exhibits. This motion is hereby denied.

[3] The following abbreviations will be used throughout this decision when citing evidence of record: Trial Transcript Pages- (Tr. __); Joint Exhibit- (JX __, pg.__); Employer's Exhibit- (EX __, pg.__); and Claimant's Exhibit- (CX __, pg.__).

Statement of the Evidence

Claimant's Testimony

Claimant, a veteran of the first Gulf War, became a truck driver following his time in the military. (Tr. 16). In the four years prior to his employment with Employer, Claimant worked as a truck driver earning $13.00 to $14.00 per hour and working sixty hours per week. He earned time and a half for every hour he worked over forty hours, and he estimated that he made about $63,000 per year. (Tr. 35-36).

In January 2004, Claimant went to Iraq to drive trucks for Employer. (Tr. 17). On April 8, 2004, he was shot in the left leg by small arms fire while driving his truck. (Tr. 17-18). After emergency treatment, Claimant was sent to Germany, where he underwent approximately ten surgeries prior to returning to the United States. (Tr. 18). After his return to the United States, Claimant underwent another two or three reconstructive surgeries plus a knee scope. (Tr. 19). Currently, Claimant complains of chronic left knee pain, and his orthopedic physician, Dr. Cooke, has scheduled another knee scope for September 2008; however, Employer/Carrier have ceased paying the bills for medical treatment and prescriptions related to Claimant's leg injury. (Tr. 20, 25).

In addition to his knee injury, Claimant says he suffers PTSD, which came about after his hospitalization. (Tr. 21). According to Claimant, he experiences severe depression, anxiety attacks, panic attacks, flashbacks and nightmares, and he has trouble sleeping. (Tr. 21). Claimant has seen a psychologist, Dr. Brinkman, for this condition, but Employer/Carrier have ceased paying for both Dr. Brinkman's bills and the medications prescribed by Dr. Hubbard, Dr. Brinkman's associate. (Tr. 21, 25). This has caused many interruptions in treatment. (Tr. 24).

Because of the need to support his family, and despite his physical and emotional problems and the large doses of prescribed medications he takes, in February 2008 Claimant took a job as a truck driver hauling heavy equipment. (Tr. 20, 24, 29). Claimant admitted that he did not tell his new employer about the medications he was taking, but he did disclose his disability. (Tr. 24, 39-40). He says the medications make him drowsy and he has to stop and take naps during the

day. (Tr. 25). Claimant stated his doctors told him it was not safe to be driving under the influence of these medications. (Tr. 22, 26). In addition, Claimant said that he is unable to work as hard or for as long as he could prior to his injury, and his leg has difficulty handling the stress and strain of his new job. (Tr. 20).

At his present job, Claimant works approximately eight hours a day, five days a week, but he is unable to work extra hours. (Tr. 29, 32). His present earnings are $12.00 per hour for approximately forty-two hours per week. (Tr. 31-32). He denied experiencing any injuries at his current job. (Tr. 33). Claimant expressed an interest in undergoing training to learn new skill sets for less physically demanding jobs, but he presently cannot afford to pursue these options. (Tr. 26).

Medical Evidence

Left Leg Injury

Medical Records of Hendrick Medical Center (EX-12)

Claimant was admitted to Hendrick Medical Center in Abilene, Texas, on April 20, 2004. On April 8, 2004, while working as a truck driver in Iraq, his convoy came under attack by small arms fire and Claimant was shot in the left femur. He was initially treated in Baghdad with incision and drainage (I&D) and external fixation of the left femur. A few days later, he was transported to Ramstein Air Force Base in Lonstul, Germany, where he received two more I&Ds. On April 19, 2004 Claimant was airlifted to Abilene, Texas, where he and his family reside, and admitted to Hendrick Medical Center under the care of Dr. Shannon E. Cooke. (EX-12, p. 27).

On April 20, 2004, Dr. Cooke examined Claimant. Based upon his initial examination, Dr. Cooke concluded that Claimant suffered from a grade 3A open left femur fracture secondary to a gunshot wound. (EX-12, p. 28). Also on this date, x-rays of Claimant's left femur and left knee were taken and revealed a distal femur fracture with an external fixation apparatus holding the fracture of the left femur. (EX-12, pp. 34, 51). Dr. Cooke performed another I&D on April 22, 2004. (EX-12, p. 30).

On April 28, 2004, Claimant was examined by Dr. John H. Gullett, who was to arrange outpatient antibiotic therapy upon Claimant's discharge. Claimant's wound appeared to be healthy, but a culture on April 24, 2004 was growing highly-resistant bacteria. (EX-12, p. 22). Dr. Gullett recommended continuing antibiotics. (EX-12, p. 23).

On May 3, 2004, Claimant was discharged from Hendrick Medical Center. (EX-12, p. 51). Claimant was to continue outpatient antibiotic therapy with Dr. Gullett. Dr. Cooke would also be following Claimant's condition. (EX-12, p. 52).

Claimant was re-admitted to Hendrick Medical Center on October 11, 2004. The treatment of Claimant's leg fracture had become complicated by the reappearance and growth of bacteria. As a result, Claimant underwent surgery in order to remove the hardware in his left leg and to collect tissue and bone samples of his left femur. (EX-12, p. 199). These samples revealed acute inflammation of the soft tissue and acute osteomyelitis of the bone. (EX-12, p. 196). It was recommended that Claimant combat the bacteria growth through IV antibiotics, which required a lengthy hospital stay with the Hendrick Center for Extended Care. (EX-12, p. 199). Claimant was discharged on November 23, 2004. (EX-12, p. 231).

Dr. Shannon E. Cooke (CX-13, EX-12)

Dr. Cooke first treated Claimant outside of Hendrick Medical Center on May 7, 2004. Dr. Cooke gave him instructions on continued care, including range of motion exercises for him to do at home. Claimant was to refrain from putting any weight on his left leg. (EX-12, p. 62). Dr. Cooke took Claimant off of work and expected him to remain off of work indefinitely. (EX-12, p. 63).

On May 14, 2004, Claimant told Dr. Cooke that he had slipped in the rain, put some weight on his left leg and felt something pop. X-rays of his left leg did not show any appreciable change and there was minimal swelling. Dr. Cooke encouraged Claimant to begin physical therapy.[4] (EX-12, p. 62).

[4] Claimant attended physical therapy from May 18, 2004 to September 30, 2004, from December 21, 2004 to January 21, 2004, and from February 11, 2005 to March 22, 2005. (EX-12, pp. 77, 81, 85, 92-93, 99, 132, 138, 148, 162, 177-178, 240, 242-244, 263, 265, 267, 273, 275).

On May 21, 2004, Dr. Cooke commented that Claimant was doing very well. He recommended that Claimant not put any weight on his left leg and kept him off of work indefinitely. (EX-12, pp. 62, 75). When Claimant returned on June 4, 2004, x-rays of his left leg showed that his fracture was healing. (EX-12, p. 62). Dr. Cooke expected Claimant to be able to return to work on August 1, 2004. (EX-12, p. 90).

On June 16, 2004, Claimant reported some popping, crackling, and pain in the medial aspect of his left knee. Dr. Cooke opined that there may be some synovitis and inflamed synovial plica, and decided to observe him. (EX-12, p. 94). Dr. Cooke took Claimant off of work indefinitely. (EX-12, p. 95).

On July 6, 2004, Claimant complained of having intermittent fevers, up to 102 or 103 degrees, and swelling in his knee. He told Dr. Cooke that his knee had become so swollen over the weekend that he had visited the emergency room to get it aspirated. Claimant was not on any antibiotics at this time. X-rays revealed interval healing of the fracture. Dr. Cooke recommended that Claimant get an MRI of his left knee and thigh. (EX-12, p. 94).

The MRIs were performed on July 7, 2004. They showed abnormal enhancement around the knee and synovial thickening and large joint effusion, and abnormal enhancement extending along the distal femur and probable enhancement of the marrow cavity. Incomplete healing of the distal femur was suspicious for osteomyelitis. Myositis was also present, but no obvious abscess was seen within the distal femur. Based on these results, Dr. Cooke was unable to rule out a septic joint. (EX-12, pp. 105, 107). He continued to keep Claimant off of work indefinitely. (EX-12, p. 110).

On July 15, 2004, Dr. Cooke performed an arthroscopy of Claimant's left knee in order to rule out septic arthritis. This procedure included a culture of synovial fluid, a biopsy of synovium, I&D, and radical synovectomy. (EX-12, p. 112).

Claimant returned to see Dr. Cooke on July 23, 2004. He continued to experience general malaise and a low grade fever. The cultures were negative, and the biopsy revealed acute and chronic reactive synovitis. Dr. Cooke recommended resuming physical therapy and continuing antibiotics. (EX-12, p. 125). He felt Claimant would be able to return to work on September 1, 2004. (EX-12, p, 124).

On August 25, 2004, Claimant still had some swelling in the knee but his motion was improving. X-rays revealed that his fracture was consolidating. Dr. Cooke decided to allow him to begin progressive weight bearing, still using his crutches. (EX-12, p. 125). He took him off of work indefinitely. (EX-12, p. 157).

On September 17, 2004, Claimant returned for a follow-up. He continued to have pain but quit taking pain medication because he did not feel it was helping. All in all, Dr. Cooke concluded that Claimant was doing quite well and contemplated removing the plate in Claimant's left femur in early November. (EX-12, p. 125). He continued to keep him off of work. (EX-12, p. 173).

When Claimant returned on October 5, 2004, he once again was experiencing some mild generalized malaise and lightheadedness. (EX-12, p. 185). Dr. Cooke noted there was a possibility that the plate would have to come out before November, especially since his fracture had healed, in order to wash out his leg. (EX-12, pp. 185-186). He kept Claimant off of work. (EX-12, p. 188).

Claimant did not see Dr. Cooke again, outside of Hendrick Medical Center, until December 7, 2004. His fixation hardware had been removed in order to treat bacterial growth in his left femur. Due to his lengthy hospital stay, Claimant had limited strength and stamina, so Dr. Cooke recommended a return to physical therapy. (EX-12, p. 186). He felt Claimant would be able to return to work on February 2, 2005. (EX-12, p. 234).

On January 25, 2005, Claimant returned to Dr. Cooke with increasing symptoms in his knee, including painful popping and grinding. Dr. Cooke sent him for an MRI of his left knee. (EX-12, p. 249). He took Claimant off of work indefinitely. (EX-12, p. 250).

On February 2, 2005, Claimant was continuing to have mechanical symptoms of pain, swelling, and catching and locking in the knee. His MRI showed a peripheral tear of the posterior horn of the medial meniscus. (EX-12, p. 249). Dr. Cooke recommended an arthroscopy of the left knee, which was performed on February 10, 2005, along with a medial and lateral meniscectomy. (EX-12, pp. 252, 256). He also kept Claimant off of work until June 1, 2005. (EX-12, p. 254).

When Claimant returned for a follow-up on February 6, 2005, he was doing well. (EX-12, p. 252). Dr. Cooke felt Claimant would be able to return to work on May 1, 2005. (EX-12, p. 264).

On March 23, 2005, Claimant's condition had improved, but he was still complaining of some pain. He expressed concern about his ability to return to his job as a truck driver, specifically whether he would be able to perform the required physical labor involved, including loading, strapping and tarping down freight, as well as the frequent walking required were he to continue working overseas. Dr. Cooke recommended he undergo a functional capacity evaluation (FCE). He opined that he was very close to reaching maximum medical improvement (MMI). (EX-12, p. 252). He felt Claimant would be able to return to work on June 1, 2005. (EX-12, p. 278).

Claimant next saw Dr. Cooke on April 8, 2005 and told him that he had overworked his left knee in therapy, resulting in popping and swelling. Dr. Cooke decided that Claimant needed a knee brace, but recommended that he continue with work conditioning. (EX-12, p. 294).

On May 4, 2005, Dr. Cooke noted that Claimant was most likely ready to return to work, but probably not heavy work. He was awaiting the results of Claimant's FCE. On the physical therapist's recommendation, Dr. Cooke wrote a prescription for Claimant to continue his sessions. (EX-12, p. 294). He took him off of work indefinitely. (EX-12, p. 300).

On May 6, 2005, Dr. Cooke wrote a letter describing Claimant's injury and treatment. It had been a little over one year since Claimant's injury, and he had completed physical therapy. At this point, Dr. Cooke placed Claimant at MMI, and stated that he foresaw no definite need for any further treatment, but noted that there was a possibility he would require additional treatment in the future. (EX-12, pp. 301-302).

Dr. Cooke did not see Claimant again until March 24, 2006. (EX-12, p. 412). Claimant had overworked his knee on a Boy Scout trip and was experiencing some pain and swelling. He denied any significant popping, catching or locking. An x-ray of Claimant's left leg showed interval maturation of the callus on the femur fracture but no other significant changes. Overall, Dr. Cooke opined that his knee looked good. He diagnosed Claimant with a knee strain, but he felt this would improve and recommended Claimant watch it closely. (EX-12, p. 358).

The next time Claimant returned to Dr. Cooke was almost two years later, on March 5, 2008. Claimant complained of thigh and knee pain and swelling. He had returned to work driving trucks and he told Dr. Cooke he was more active than he had previously been. Dr. Cooke recommended that Claimant get an MRI of his thigh and knee to rule out any latent infection. (CX-13, p. 2; EX-12, p. 405). He wrote that Claimant would be able to return to work that same day. (EX-12, p. 408).

Claimant returned on April 1, 2008. His pain had increased since he had returned to work. He occasionally experienced spasms and cramps, and his knee was popping, grinding and catching more frequently. He described the pain as fairly constant and severe at times. (CX-13, p. 2; EX-12, p. 411). His limping was also becoming more exaggerated and would worsen throughout the course of the day, to the point where he was unable to do much of anything after work. Dr. Cooke felt that Claimant's persistent symptoms warranted an MRI. (CX-13, p. 3; EX-12, p. 412). On April 23, 2008, Dr. Cooke reported that Claimant's MRI showed chondromalacia patella, and he administered an injection. (CX-13, p. 4).

On July 23, 2008, Claimant continued to complain of recurrent pain in his knee. His MRI showed chondromalacia patella, low grade signal change and prior surgical changes. The injection Dr. Cooke administered helped only briefly and Claimant continued to struggle with pain and mechanical symptoms in his left knee. Because of the evidence of progressive patellofemoral changes in his left knee and his failure to respond to conservative treatment, Dr. Cooke recommended that Claimant undergo a left knee arthroscopy with abrasion chondroplasty of the patellofemoral joint. (CX-13, pp. 4-5).

Dr. John H. Gullett (EX-12)

After Claimant's discharge from Hendrick Medical Center on May 3, 2004 (*See* EX-12, p. 51), Dr. Gullett began treating Claimant for the infection that developed in his left leg as a result of his injury. On May 4, 2004, Dr. Gullett recommended that Claimant undergo eight weeks of IV therapy for his bone infection. (EX-12, p. 57).

On July 20, 2004, Dr. Gullett reported that Claimant had begun experiencing swelling and joint effusion in his left leg. He discussed the situation with Dr. Cooke, who told Dr. Gullett that an arthroscopy of Claimant's left knee had revealed infection in the joint fluid. Dr. Gullett decided to continue treating Claimant's infection on an outpatient basis until the hardware could be removed, at which point he would begin formal antibiotic therapy. (EX-12, p. 120).

Dr. Gullett wrote a letter to Dr. Cooke on October 5, 2004, explaining that Claimant had been on antibiotics since July 15 but had begun complaining of pain and malaise. Dr. Gullett requested Dr. Cooke's opinion on removing the hardware in Claimant's left leg earlier than expected in order to effectively treat the infection. (EX-12, p. 184).

On October 18, 2004, Dr. Gullett noted that the hardware in Claimant's leg had been removed, and so he felt it was time to treat Claimant's bone infection with six weeks of multiple IV antibiotics given several times a day, for which he would need to be hospitalized. He also recommended that Claimant undergo hyperbaric oxygen treatment. (EX-12, p. 201).

Dr. Gullet wrote a letter to Dr. Cooke on December 14, 2004, informing him that Claimant had completed his antibiotic treatment and was doing well. He planned on continuing to follow Claimant's condition for several months before releasing him from his care. (EX-12, p. 235).

On January 24, 2005, Dr. Gullett noted that Claimant had been complaining of pain in his left knee, but he did not see any evidence of a recurrence of the infection. (EX-12, p. 246). Dr. Gullett next saw Claimant on February 3, 2005, and again failed to find any indication that the infection had returned. Overall, Dr. Gullett was "most encouraged" by Claimant's response to the antibiotic treatment. (EX-12, p. 253).

On March 24, 2005, Dr. Gullett wrote another letter to Dr. Cooke summarizing his evaluation of Claimant. He noted that Claimant had undergone arthroscopic surgery on February 10, 2005, and there were no signs of infection. He explained to Claimant that there would always be a slight possibility that the infection would return, however the probability of this happening was very low. (EX-12, p. 277).

Functional Capacity Evaluation and Records of Work & Rehab (EX-12)

On March 28, 2005, Claimant completed a FCE. The evaluation was conducted by Dolores Poyner, a physical therapist with Work & Rehab. Claimant gave a good, consistent effort throughout the evaluation. Ms. Poyner reviewed the circumstances surrounding Claimant's April 8, 2004 injury and noted that at the time of his injury, his employment as a truck driver required him to lift up to 100 pounds or more and climb onto the truck to do the strapping and tarping of freight as necessary. (EX-12, p. 279).

Ms. Poyner determined that Claimant could tolerate sitting as long as he could shift his weight. His position tolerance for walking and standing was limited to fifteen minutes, and she noticed that while walking or standing Claimant put all of his weight on his right leg 90 percent of the time, causing him to walk with a limp. Claimant's tolerance for kneeling was also limited. Claimant had to rely on handrails to climb stairs and had trouble climbing a ladder. He was unable to tolerate crawling and full squatting. Claimant was able to lift 58 pounds from the floor to his waist, using a special posture to avoid putting pressure on his left leg. He was able to lift 68 pounds from his waist to his shoulder and 63 pounds overhead. Claimant could carry 38 pounds but had difficulty pulling an empty sled. (EX-12, p. 279).

Based on the Department of Labor standards, Ms. Poyner concluded that Claimant could perform Medium-Heavy work when it came to his ability to lift, but he would have trouble with the positional tolerance required by work in that category. (EX-12, p. 279). She also determined that Claimant would have trouble with the physical duties required by his former job. She therefore recommended that Claimant participate in work conditioning and hardening programs, focusing first on strength and positional tolerance and later on lifting, pushing, and pulling, in order to get to a point where he would be able to return to his former job. (EX-12, p. 280).

Claimant attended fifteen work conditioning sessions and was discharged from the program on April 22, 2005. Throughout the conditioning, Claimant was never able to meet the physical demands required by his former employment as a truck driver in Iraq. He was able to improve his lifting from 60 to 98 pounds, but he could lift that amount only occasionally and only when modifying his lift position. Claimant was unable to tolerate walking for over twenty minutes, and he had difficulty walking on the flat surface of a treadmill, indicating that he would most likely have trouble walking on the sand and gravel in Iraq. Ultimately,

Claimant was found incapable of returning to his former employment, but he was found to be capable of working in a modified position, one that did not require climbing, walking on uneven surfaces, squatting, or frequent lifting of 100 pounds or more. (EX-12, pp. 297, 299).

Functional Capacity Evaluation dated September 9, 2005 (EX-12)

Claimant underwent a second FCE on September 9, 2005. (EX-12, p. 331). Claimant gave maximal and consistent effort on all skills tested and his pain behavior was consistent with his injury. He experienced pain when squatting, kneeling, crouching, and climbing stairs or ladders. Claimant was unable to tolerate any crawling. (EX-12, p. 331).

The results of the evaluation indicated that Claimant was able to rotate sitting and standing for an entire day, but he was unable to put pressure on his left knee. Claimant was able to lift a maximum of 70 pounds, and could carry a maximum of 55 pounds. (EX-12, pp. 332-333).

Medical Records of Dr. Wright W. Singleton (EX-12)

Dr. Singleton first saw Claimant on September 2, 2005 for an independent medical examination (IME). (EX-12, pp. 322-325). He opined that Claimant's knee had reached MMI and stated there was no reason for further treatment, except for periodic visits for prescription medications. Dr. Singleton estimated that Claimant's treatment should cease on March 2, 2006. (EX-12, p. 327).

On September 28, 2005, Dr. Singleton added to his previous report after reviewing the FCE completed on September 9, 2005. The results of the FCE indicated that Claimant could resume work at a light to heavy capacity, allowing Claimant to lift a maximum of 75 pounds and frequently carry objects weighing 45 pounds. Dr. Singleton considered Claimant's description of his job requirements as a truck driver with Employer to be within these restrictions. (EX-12, p. 338). Dr. Singleton gave Claimant a 26 percent total lower extremity impairment rating, which equaled a 10 percent whole person impairment. (EX-12, p. 339).

Psychological Treatment

Dr. Samuel Brinkman (CX-1; CX-6; CX-8; EX-12)

Dr. Samuel D. Brinkman, a clinical neuropsychologist, first examined Claimant on May 10, 2005. (EX-12, p. 303). Claimant described his injury of April 8, 2004, and told Dr. Brinkman that he had not gone back to work since that time. Claimant reported having trouble sleeping and experiencing nightmares. He had flashbacks, obsessed over the ambush that caused his injury, and constantly felt nervous, anxious or hypervigilant. His anxiety attacks caused his body to tense and he would want to scream. He avoided newspapers and news programs, especially those discussing the conflict in Iraq or other combat-type situations. Claimant suffered from severe depression, and felt apathetic, passive and hopeless. He was also prone to crying spells. (EX-12, p. 303).

Dr. Brinkman found Claimant's mental status to be alert and well-oriented. His speech was clear and relevant, and his thought processes and abstract reasoning skills reflected average intellectual function. Claimant's affect was somewhat controlled, and his mood appeared anxious and depressed. Claimant told Dr. Brinkman that he passively contemplated suicide, but there was no history of an attempt. (EX-12, p. 304).

After this initial examination of Claimant, Dr. Brinkman diagnosed Claimant with PTSD and recommended that he begin taking anti-depressants. (EX-12, pp. 304, 348). He referred Claimant to Dr. Joe Hubbard, who would become Claimant's primary psychological physician and prescribe the medications Claimant required to treat his PTSD, including the anti-depressants. (EX-12, pp. 307, 309). Dr. Brinkman then began treating Claimant with the goals of improving his coping skills and sleeping habits, and decreasing his depression and PTSD symptoms. (EX-12, p. 348).

Dr. Brinkman continued to see Claimant throughout May and June 2005. Dr. Brinkman taught Claimant some relaxation techniques, which he felt had a positive effect. Claimant's incidents of anxiety and tension began to decrease, and he only became upset by the incident in Iraq if he thought about it. Dr. Brinkman's primary concern was Claimant's inability to sleep. (EX-12, pp. 306-307, 309-310).

In July and August 2005, Dr. Brinkman noted that Claimant had begun taking anti-depressants and sleeping medications prescribed by Dr. Hubbard. Claimant felt the anti-depressants were working and was only experiencing a few instances of anxiety. He was beginning to speak more freely about stressors in his life, but he continued to avoid discussing the circumstances surrounding his injury. Despite these improvements, Claimant's inability to sleep persisted. Dr. Brinkman wrote a note to Dr. Hubbard recommending that he prescribe a sleep study for Claimant. (EX-12, pp. 313, 315-317, 319).

Claimant's mood and ability to handle his anxiety continued to improve throughout September 2005. Claimant had a generally positive outlook and showed improvement in management of his life's activities. His medications appeared to be working. However, he still could not sleep. Dr. Brinkman reported that Claimant was having trouble getting the sleep study approved by Carrier. (EX-12, pp. 330, 335).

On October 3, 2005, Dr. Brinkman terminated his treatment of Claimant. (EX-12, p. 341). On November 8, 2005, he completed an MMI Report and assigned an impairment rating to Claimant's psychological condition. (EX-12, p. 348). In determining the impairment rating, Dr. Brinkman discussed and analyzed Claimant's activities of daily living, his social functioning, his concentration, and his ability to adapt to stressful situations. Claimant's activities of daily living had been disrupted as a result of his psychological condition, in that he was having trouble sleeping and his mobility had decreased due to his fear of re-injuring his left leg. (EX-12, p. 349). As for his social interaction, Claimant's depression and anxiety made it difficult to establish and maintain relationships, causing Claimant to isolate himself and avoid social situations. (EX-12, p. 349). Dr. Brinkman noted that Claimant's ability to concentrate had improved with treatment, but he became easily fatigued and had a tendency to leave projects unfinished. (EX-12, p. 349). Dr. Brinkman also found Claimant to have a very low tolerance for stress. (EX-12, p. 349). Based on his analysis of these issues, Dr. Brinkman estimated Claimant's psychological impairment rating to be 12 percent. (EX-12, p. 349).

Claimant did not return to Dr. Brinkman until February 2006. He was still sleeping poorly and had begun experiencing flashbacks and nightmares, but had yet to participate in the sleep study. Dr. Brinkman encouraged Claimant to increase his activity and perform tasks that would give him a sense of productivity and utility. (EX-12, p. 354).

Claimant followed Dr. Brinkman's recommendation and became involved in some leadership activities with the Boy Scouts. When he returned to see Dr. Brinkman in March 2006, he appeared more positive and hopeful. He was no longer having nightmares and flashbacks, although he was experiencing some troubling thoughts about his injury in Iraq. (EX-12, p. 355).

On June 13, 2006, Dr. Brinkman completed a Work Capacity Evaluation (Form OWCP-5a) stating that Claimant was unable to work eight hours a day due to poor concentration, sleep disturbance, flashbacks, irritability and depression, all related to his PTSD. Dr. Brinkman stated Claimant could not return to his former job, and he was uncertain as to when Claimant would be able to work. (CX-1; EX-12, p. 362).

Almost a year passed before Dr. Brinkman saw Claimant again, on May 30, 2007. Claimant's anxiety attacks had improved, but his sleep patterns remained erratic. He continued to be very depressed and described his life as undirected, unfocused and purposeless. Claimant expressed concern over his lack of excitement over the impending birth of his child. Dr. Brinkman opined that Claimant's medication dosage might need to be increased, and he advised Claimant to begin a workout program. He also recommended that Claimant find activities that he could do to benefit others, as that might decrease the self-focus of his depression. (EX-12, p. 384).

Claimant did not return to Dr. Brinkman until March 12, 2008. He was still experiencing symptoms of PTSD, including intrusive thoughts and troublesome dreams. He continued to have trouble sleeping. These manifestations of the PTSD were interfering with Claimant's new job as a truck driver. Nevertheless, Dr. Brinkman felt that Claimant's recent employment was an example of his efforts to overcome the symptoms of PTSD. (EX-12, p. 409).

On March 20, 2008, Dr. Brinkman wrote a note at the request of Claimant's attorney. He stated that Claimant continued to experience symptoms of PTSD, with poor sleep, intrusive thoughts, hypervigilance, high anxiety, chronic tension and irritability, poor tolerance for frustration, and depression. Claimant had increased his productivity in spite of these symptoms. (CX-8; EX-12, p. 410).

Dr. Brinkman continued to treat Claimant throughout April and May 2008. Claimant was struggling with depression and anxiety, and he felt he was approaching an emotional breakdown. He often felt the urge to become aggressive. However, he felt the routine of his job was good for him, even though

many of the activities involved left him in great physical pain. Claimant also continued to have trouble sleeping. He told Dr. Brinkman that he was able to keep his mind engaged during the day, thereby keeping intrusive thoughts at bay, but this was not the case at night. Dr. Brinkman noted that the sleep study he had recommended had been denied twice. (CX-6, p. 3; CX-14, pp. 1-2).

Dr. Joe Hubbard (CX-3; CX-10; CX-11; EX-12)

Dr. Brinkman referred Claimant to Dr. Hubbard for fulfillment and maintenance of Claimant's prescription medications related to his psychological condition. Dr. Hubbard first saw Claimant on July 11, 2005, and continued seeing him on a regular basis. (EX-12, pp. 312, 318, 321, 347, 351, 353, 356, 359, 360-361, 366-367, 371-372, 374-375, 379, 393-394, 397-400).

On June 12, 2006, Dr. Hubbard completed a Progress Report. (CX-3, p. 1; EX-12, p. 360). He wrote that he planned to continue treating Claimant indefinitely. Claimant was not working and Dr. Hubbard was uncertain as to when Claimant would be able to return to work, primarily due to the PTSD that resulted from his April 8, 2004 injury. Dr. Hubbard stated Claimant needed continuing psychological counseling and medical interventions and recommended that Claimant undergo rehabilitation. (CX-3, p. 2; EX-12, p. 361).

On November 28, 2007, Dr. Hubbard diagnosed Claimant with sleep apnea and wrote a prescription for a sleep study. (CX-11). On February 8, 2008, Dr. Hubbard's office received a message from Carrier stating that it would no longer pay Claimant's medical bills. This message notified Dr. Hubbard that Claimant would be responsible for all medical charges from that point. (CX-10).

Other Evidence

Claimant's Wage Records (EX-10)

From April 11, 2003 until October 15, 2003, Claimant was employed by Delta Metals. His estimated weekly earnings totaled $850.00, therefore his entire earnings from the 26.86 weeks he worked for Delta Metals equaled $22,828.57. (EX-10, p.1).

Claimant next went to work for TWI from October 2003 until his employment with Employer, about 12.43 weeks. His estimated weekly earnings totaled $850.00; therefore, his total earnings from his employment with TWI amounted to $10,564.29. (EX-10, p.1).

Claimant worked for Employer for approximately 12.71 weeks, from January 11, 2004 to April 8, 2004. He earned a total of $21,457.25 from this employment, which equals approximately $1,687.65 per week. (EX-10, pp. 1-2).

Overall, from April 11, 2003 until April 8, 2004, Claimant earned a total of $54,850.11.

Employer's Notice of Final Payment or Suspension of Compensation Payments, DOL Form LS-208 (EX-8)

From April 9, 2004, to September 2, 2005, Employer/Carrier paid a total of $49,488.24 in compensation to Claimant for temporary total disability to his left leg based on an average weekly wage of $1,003.14. Employer also paid Claimant compensation for a scheduled loss permanent partial disability for 112 weeks, resulting from the 26 percent impairment to his left lower extremity, totaling $74,901.12.

Prescriptions Claimant Paid for Out-of-Pocket (CX-9)

On April 26, 2008, Claimant paid $75.16 for four prescriptions, one of which was written by Dr. Cooke and the rest by Dr. Hubbard. (CX-9, p. 2-3). On May 5, 2008, Claimant paid $68.91 for three prescriptions written by Dr. Hubbard. (CX-9, pp. 4-5). On June 4, 2008, Claimant paid $59.10 for three prescriptions written by Dr. Hubbard. (CX-9, p. 6). On June 12, 2008, Claimant paid $9.97, on July third he paid $29.52, and on July 23, 2008, he paid $16.23, all for medications prescribed by Dr. Hubbard. (CX-9, pp. 1, 7-8). Overall, Claimant paid $258.89 for these prescriptions.

Pharmacy Records (CX-12)

On May 5, 2008, the pharmacy where Claimant gets his prescription filled flagged a medication prescribed by Dr. Hubbard as being a high dosage. (CX-12, p. 1).

F[redacted]

Claimant's Medical Bills (CX-7; CX-13)

As of May 7, 2008, Claimant owed $700.00 for his treatment with Dr. Brinkman from December 11, 2007 through April 23, 2008. (CX-7, p. 1). As of July 23, 2008, Claimant had an outstanding medical bill from Dr. Cooke in the amount of $155.00. (CX-13, p. 6).

Findings of Fact and Conclusions of Law

The following findings of fact and conclusions of law are based upon my observation of the appearance and demeanor of the witnesses who testified at the hearing and upon an analysis of the entire record, arguments of the parties, and applicable regulations, statutes, and case law. In evaluating the evidence and reaching a decision in this case, I have been guided by the principles enunciated in *Director, OWCP v. Greenwich Collieries (Maher Terminals)*, 512 U.S. 267, 28 BRBS 43 (1994), that the burden of persuasion is with the proponent of the rule. Additionally, as trier of fact, I may accept or reject all or any part of the evidence, including that of medical witnesses, and rely on my own judgment to resolve factual disputes or conflicts in the evidence. *Todd Shipyards v. Donovan*, 300 F.2d 741 (5th Cir. 1962). The Supreme Court has held that the "true doubt" rule, which resolves conflicts in favor of the Claimant when the evidence is balanced, violates Section 556(d) of the Administrative Procedures Act. *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267, 28 BRBS 43 (1994).

Causation

Section 20(a) of the Act provides a Claimant with a presumption that his disabling condition is causally related to his employment if he shows that he suffered a harm, and that employment conditions existed which could have caused, aggravated, or accelerated the condition. *Merrill v. Todd Pacific Shipyards Corp.*, 25 BRBS 140 (1991); *Stevens v. Tacoma Boat Building Co.*, 23 BRBS 191 (1990). The Section 20(a) presumption operates to link the harm with the injured employee's employment. *Darnell v. Bell Helicopter Int'l, Inc.*, 16 BRBS 98 (1984).

Once the Claimant has invoked the presumption, the burden shifts to the employer to rebut the presumption with substantial countervailing evidence and show that the claim is not one "arising out of or in the course of employment." 33 U.S.C. §§ 902(2), 903; *Ortco Contractors, Inc. v. Charpentier*, 332 F.3d 283 (5th Cir. 2003); *James v. Pate Stevedoring Co.*, 22 BRBS 271 (1989). Substantial

evidence has been defined as such relevant evidence as a reasonable mind might accept to support a conclusion. *Sprague v. Director, OWCP,* 688 F.2d 862, 865 (1st Cir. 1982). If there has been a subsequent non-work-related event, employer can establish rebuttal of the Section 20(a) presumption by producing substantial evidence that claimant's condition was not caused by the work-related event. *James v. Pate Stevedoring Co.*, 22 BRBS 271 (1989). Employer is liable for the entire disability if the second injury is the natural or unavoidable result of the first injury. Where the second injury is the result of an intervening cause, employer is relieved of liability for that portion of disability attributable to the second injury. *Bailey v. Bethlehem Steel Corp., 20 BRBS 14 (1987).* If the employer meets its burden, the Section 20(a) presumption is rebutted and disappears, and the administrative law judge must weigh all the evidence and render a decision supported by substantial evidence. *Del Vecchio v. Bowers*, 296 U.S. 280 (1935).

In the present case, the parties have stipulated that Claimant's left leg was injured in the course and scope of his employment with Employer on April 8, 2004. What is contested is whether that same April 8, 2004 incident led to Claimant's Post-Traumatic Stress Disorder (PTSD).

The DSM-IV describes the essential feature of PTSD as the "development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person." (Diagnostic Criteria for 309.81, PTSD, p. 424).

Characteristic symptoms resulting from extreme trauma include persistent re-experiencing of the traumatic event, persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness, and persistent symptoms of increased arousal. Traumatic events that are experienced directly include, but are not limited to, military combat, violent personal assault, being kidnapped, being taken hostage, terrorist attack, torture, incarceration as a prisoner of war or in a concentration camp, natural or manmade disasters, severe automobile accidents, or being diagnosed with a life-threatening illness.

Witnessed events include, but are not limited to, observing the serious injury or unnatural death of another person due to violent assault, accident, war, or

disaster or unexpectedly witnessing a dead body or body parts. Traumatic events can be re-experienced in various ways; commonly the person has recurrent and intrusive recollections of the event or recurrent distressing dreams during which the event is replayed. Stimuli associated with the trauma are persistently avoided. Id.

A differential diagnosis requires that malingering be ruled out in those situations in which financial remunerations, benefits eligibility and forensic determinations play a role. Id., at 427.

On April 8, 2004, the truck Claimant was driving came under attack by small arms fire, and Claimant was shot in the left leg. When the attack began, he crouched down in his truck, but once he was shot, he got out and sought shelter behind the wheels on the opposite side of the truck. Claimant ran around the truck until his left leg gave out, at which point he crawled behind the wheels. (EX-12, p. 22).

Overall, the attack on Claimant's convoy lasted about forty-five minutes. Claimant estimated that he was shot about twenty minutes into the attack. Another thirty minutes passed after the attack ended before he was seen by medics. Claimant was transported by Hum-vee to the Baghdad Airport and then transferred to a trauma unit in Baghdad City. He was moved once again, this time to a medical site on the outskirts of Baghdad, before he was sent by air to the Landstuhl Medical Center in Germany. (EX-12, p. 22). Throughout this time, Claimant underwent many medical procedures, including I&Ds and reconstructive surgeries. On April 19, 2004, he was finally airlifted back to the United States, where he was admitted to Hendrick Medical Center in Abilene, Texas, under the care of Dr. Cooke. (EX-12, p. 27).

In addition to the physical damage to his leg caused by the bullet, Claimant's wound became exposed to rare bacteria, causing it to become infected. (EX-12, p. 22). Throughout the remainder of 2004 and much of 2005, Claimant was not only treated for the fracture to his left femur, but he also underwent intense antibiotic therapy for treatment of this infection, requiring lengthy hospitalization. (EX-12).

F[redacted]

Claimant was diagnosed with PTSD by Dr. Brinkman on May 10, 2005. (EX-12, pp. 303-304). He was having trouble sleeping and experiencing nightmares. He was also obsessing over the attack, having flashbacks, and constantly feeling nervous, anxious or hypervigilant. He was avoiding coming into contact with any news of the conflict in Iraq or other combat-type situations. He was also feeling depressed, apathetic, and hopeless. (EX-12, p. 303).

Claimant was treated medically for his PTSD by Dr. Hubbard. On June 12, 2006, Dr. Hubbard completed a progress report that stated Claimant's PTSD was a result of the attack and injury that occurred on April 8, 2004. (CX-3, pp. 1-2). This report, along with the diagnosis and treatment administered by Dr. Brinkman, leads me to conclude that Claimant suffered a psychological harm and this harm was caused by his employment with Employer, thereby establishing a prima facie case of compensability.

Employer/Carrier rely on only one argument to rebut this presumption, specifically that Claimant did not complain of suffering any psychological symptoms until well over a year after he was injured. However, given the nature of Claimant's orthopedic injury and the protracted hospitalization and treatment resulting from the bone infection, I do not find it unreasonable that Claimant waited until resolution of those conditions before seeking medical attention for his psychological problems. Claimant was hospitalized at Hendrick Medical Center and Hendrick Medical Center's long-term care center from October 11, 2004 through November 23, 2004 for treatment of his bone infection, and Dr. Gullet did not release Claimant from his care until March 24, 2005. He underwent surgery on his left leg to repair a tear as late as February 10, 2005, and was not released from Dr. Cooke's treatment until May 6, 2005. (EX-12, pp. 256, 301-302). Given the severity of his injury and the complications brought about by the bone infection, as well as the potential latency of PTSD symptoms, I find that Employer/Carrier has failed to rebut the presumption of compensability.

Even if Employer/Carrier had rebutted the Section 20(a) presumption, after weighing the evidence as a whole, I would still come to the conclusion that Claimant's PTSD is a compensable injury. Claimant's testimony was credible. He experienced a traumatic event that led to severe physical injury and a lengthy and painful recovery process. He has trouble sleeping, has nightmares and flashbacks, avoids social situations and all discussion of the conflict in Iraq, and is anxious, nervous, depressed, apathetic, and hypervigilant. There is no evidence of malingering from either doctor who treated Claimant for his PTSD; in fact,

be able to withstand the positional tolerance required by work at that level. (EX-12, p. 279). The FCE demonstrated that Claimant was not physically able to perform those duties required by his previous employment, but there was a possibility he could progress to that point through work conditioning. (EX-12, p. 280).

Nevertheless, after fifteen sessions of occupational therapy, Claimant's physical capabilities still fell short of those required by his former job. The occupational therapist working with Claimant concluded that he was unable to return to his former employment, but he would be able to work in a modified position, one that did not require climbing, walking on uneven surfaces, squatting, or frequent lifting of 100 pounds or more. (EX-12, p. 299).

Claimant's second FCE, performed on September 9, 2005, also demonstrated that he was unable to return to his previous employment. (EX-12, p. 331). It indicated that Claimant could lift up to 70 pounds and carry 45 pounds frequently, but he experienced pain when squatting, kneeling, crouching, and climbing stairs or ladders. Claimant was unable to crawl or put any pressure on his left knee. (EX-12, pp. 332-333). These results are inconsistent with the duties of his former job. Therefore, I find that Claimant's leg injury prevented him from returning to his former employment.

In regards to Claimant's psychological condition, on June 12, 2006, Dr. Hubbard opined that Claimant was unable to return to work due to his PTSD. (CX-3, p. 2). The following day, Dr. Brinkman came to the same conclusion, and specifically wrote that Claimant could not return to his former employment. (CX-1). Both doctors were uncertain as to when Claimant would be able to work. (CX-1; CX-3, p.2). In light of these medical opinions, I also find Claimant's psychological condition precludes him from resuming his previous employment.

To establish suitable alternative employment, an employer must show the existence of realistically available job opportunities within the claimant's geographical area which he is capable of performing, considering his age, education, work experience and physical restrictions, for which the claimant is able to compete and could likely secure if he diligently tried. *New Orleans (Gulfwide) Stevedores v. Turner*, 661 F.2d 1031, 1042-43, 14 BRBS 156, 164-65 (5th Cir. 1981).

Turner does not require that the employer find specific jobs for the claimant or act as an employment agency for the claimant; rather, the employer may simply demonstrate the availability of general job openings in certain fields in the surrounding community. *P & M Crane Co. v. Hayes*, 930 F.2d 424, 431 (5th Cir. 1991); *Avondale Shipyards, Inc. v. Guidry*, 967 F.2d 1039, 1044 (5th Cir. 1992). However, for job opportunities to be realistic, the employer must establish the precise nature and terms of job opportunities which it contends constitute suitable alternative employment. *Thompson v. Lockheed Shipbuilding & Constr. Co.*, 21 BRBS 94, 97 (1988). The administrative law judge must compare the jobs' requirements identified by the vocational expert with the claimant's physical and mental restrictions based on the medical opinions of record. *Villasenor v. Marine Maint. Indus., Inc.*, 17 BRBS 99, 103 (1985). Once the employer demonstrates the existence of suitable alternative employment, the claimant can nonetheless establish total disability by demonstrating that he tried with reasonable diligence to secure such employment and was unsuccessful. *P & M Crane Co.*, 930 F.2d at 430.

In the present case, Employer/Carrier argue that they have met the burden of establishing suitable alternate employment because Claimant resumed working as a truck driver for a different employer in February 2008. (Tr. 20, 24, 29). However, the fact that a claimant works after an injury does not always preclude a finding of total disability. *Haughton Elevator Co. v. Lewis*, 572 F.2d 447 (4th Cir. 1978). One situation in which a claimant will be found totally disabled despite returning to work after his injury occurs when he continues his employment through extraordinary effort and despite considerable pain and diminished strength. *Id.* The Board has cautioned against broad application of these cases and emphasized that these circumstances are the exception and not the rule. *Chase v. Bethlehem Steel Corp.*, 9 BRBS 143 (1978).

Both doctors treating Claimant for his PTSD opined that Claimant would be unable to return to work for eight hours a day, and that he was unable to return to his former employment. (CX-1; CX-3, p. 2). Yet without revealing his medications, Claimant sought and obtained a job as a truck driver hauling heavy equipment, working approximately 42 hours a week, in order to make money to support his family. (Tr. 20, 24, 29). The medications he takes for his PTSD affect his job performance by making him drowsy, and he has to pull over several times a day to take naps, all of which he knows makes it unsafe for him to work as a truck driver. (Tr. 25). Likewise, the pharmacy has flagged some of these medications for being high dosages. (CX-12, p. 1).

Furthermore, Claimant's return to work coincided with a return of his left knee symptoms. Claimant returned to see Dr. Cooke for pain and swelling in his left knee on March 5, 2008, almost two years after his previous appointment. (CX-13, p. 2). On a subsequent visit, on April 1, 2008, Claimant was experiencing spasms, cramps, popping, grinding and catching in his knee. He described his pain as constant and severe, and stated that his limping would worsen during the day, to the point that he was unable to do much of anything after his workday. (CX-13, pp. 2-3). Claimant was glad to get back to work, but stated that many of the activities involved left him in great physical pain. (CX-6, p. 3). Dr. Cooke ordered an MRI, and on July 23, 2008, recommended that Claimant undergo further surgery to address his knee problems. (CX-13, pp. 3-5).

In sum, despite warnings from the doctors treating his PTSD that he should not return to work, and despite a recurrence of severe knee pain, Claimant returned to work as a truck driver to support his family. I find that Claimant has shown extraordinary effort in returning to work against the recommendations of his treating physicians and in spite of considerable physical pain. Therefore, despite his return to work, Claimant continues to be totally disabled.[6]

Average Weekly Wage

Section 10 sets forth three alternative methods for determining a claimant's average annual earnings, which are then divided by fifty-two, pursuant to Section 10(d), to arrive at an average weekly wage. 33 U.S.C. § 910(d)(1). The computation methods are directed towards establishing a claimant's earning power at the time of the injury. *Johnson v. Newport News Shipbuilding & Dry Dock Co.*, 25 BRBS 340 (1992); *Lobus v. I.T.O. Corp.*, 24 BRBS 137 (1990).

Sections 10(a) and 10(b) apply to an employee working full-time in the employment in which he was injured. *Roundtree v. Newpark Shipbuilding & Repair, Inc.*, 13 BRBS 862 (1981), *rev'd* 698 F.2d 743, 15 BRBS 94 (CRT) (5th Cir. 1983), *panel decision rev'd en banc*, 723 F.2d 399, 16 BRBS 34 (CRT) (5th Cir.) *cert. denied*, 469 U.S. 818 (1984). Section 10(a) applies if the employee worked "substantially the whole of the year" preceding the injury, which refers to the nature of the employment, not necessarily the duration. The inquiry should

[6] Employer/Carrier point out that on March 12, 2008, Dr. Brinkman became aware of Claimant's return to work yet failed to assign any restrictions. While Dr. Brinkman did in fact acknowledge Claimant's return to work, he identified it as evidence of Claimant's efforts to overcome his PTSD symptoms. Dr. Brinkman never indicated any intent to withdraw his opinion that Claimant should not return to work; in fact, he noted that Claimant's PTSD symptoms were interfering with his new job duties. (EX-12, p. 409).

focus on whether the employment was intermittent or permanent. *Gilliam v. Addison Crane Co.*, 21 BRBS 91 (1987); *Eleazer v. General Dynamics Corp.*, 7 BRBS 75 (1977). If the time in which the claimant was employed was permanent and steady then Section 10 (a) should apply. *Duncan v. Washington Metropolitan Area Transit*, 24 BRBS 133 (1990) (holding that 34.5 weeks of work was "substantially the whole year," where the work was characterized as "full time," "steady" and "regular"). The number of weeks worked should be considered in tandem with the nature of the work when deciding whether the Claimant worked substantially the whole year. *Lozupone v. Lozupone & Sons*, 12 BRBS 148, 153-156 (1979).

Section 10(b) applies to an injured employee who worked in permanent or continuous employment, but did not work for substantially the whole year. 33 U.S.C. § 910(b); *Empire United Stevedores v. Gatlin*, 936 F.2d 819, 25 BRBS 26 (CRT)(5th Cir. 1991). This would be the case where the Claimant had recently been hired after having been unemployed. Section 10(b) looks to the wages of other workers and directs that the average weekly wage should be based on the wages of an employee of the same class, who worked substantially the whole of the year preceding the injury, in the same or similar employment, in the same or neighboring place. Accordingly, the record must contain evidence of the substitute employee's wages. *See Sproull v. Stevedoring Servs. of America*, 25 BRBS 100, 104 (1991).

Both Sections 10(a) and 10(b) apply to an employee who worked five or six days a week. Because Claimant worked for Employer for seven days a week, both Sections 10(a) and 10(b) are inappropriate methods for determining Claimant's average weekly wage. (EX-2).

Section (c) is a catch-all to be used in instances when neither (a) nor (b) are reasonably and fairly applicable. If employee's work is inherently discontinuous or intermittent, his average weekly wage for purposes of compensation award under Longshore and Harbor Workers' Compensation Act (LHWCA) is determined by considering his previous earnings in employment in which he was working at the time of injury, reasonable value of services of other employees in same or most similar employment, or other employment of employee, including reasonable value of services of employee if engaged in self-employment. Longshore and Harbor Workers' Compensation Act, §§ 10(c), 33 U.S.C.A. §§ 910(c). *New Thoughts Finishing Co. v. Chilton*, 118 F.3d 1028 (5th Cir. 1997)

In this case, I find that Section 910(c) applies because neither (a) nor (b) can be reasonably and fairly used to determine Claimant's average weekly wage. The Administrative Law Judge has broad discretion in determining annual earning capacity under subsection 10(c). *Hayes v. P & M Crane Co., supra; Hicks v. Pacific Marine & Supply Co., Ltd.*, 14 BRBS 549 (1981). It should also be stressed that the objective of subsection 10(c) is to reach a fair and reasonable approximation of a claimant's wage-earning capacity at the time of injury. *See Story v. Navy Exch. Serv. Center,* 33 BRBS 111(1999).

One way to calculate Claimant's average weekly wage (AWW) under Section 10(c) is to use his actual earnings with Employer at the time of his injury. However, Employer/Carrier argue that calculating Claimant's AWW using only those wages he earned during the three months he was overseas would fail to represent a reasonable approximation of Claimant's earning capacity at the time of his injury. Instead, Employer/Carrier contend that Claimant's AWW should be determined by combining or blending the wages he earned during the year immediately preceding his accident, including those from Employer and those earned from other employers. In *Meyer v. Service Employees International*, 2005-LDA-77 (Feb. 7, 2006), the ALJ determined that a blended approach would provide a more true earning capacity because it would establish a compromise, and allow the claimant to benefit from higher earnings while recognizing the fact that his employment contract was at-will and only for twelve months of employment.

In this case, I agree with Employer/Carrier and find it appropriate to blend Claimant's higher earnings from Employer with those wages earned stateside during the 52 weeks prior to his injury. Similar to *Meyer*, Claimant's employment in Iraq was subject to an at-will agreement and there was no guarantee his employment would last beyond twelve months. (EX-1, pp. 1-2). Under these circumstances, I find that the most appropriate, fair and reasonable method of computing Claimant's AWW is to take into consideration Claimant's earnings in the year immediately preceding his injury on April 8, 2004.

During the 52 weeks preceding his April 8, 2004 injury, Claimant worked for three different employers. From April 11, 2003 until October 15, 2003, Claimant earned $22,828.57 from Delta Metals. From October 2003 until his employment in Iraq, Claimant earned $10,564.29 from TWI. While working overseas for Employer from January 11, 2004 to April 8, 2004, Claimant earned $21,457.25. (EX-10, p. 1). Overall, from April 11, 2003 until April 8, 2004, Claimant earned a total of $54,850.11, which when divided by 52 weeks equals an AWW of $1,054.86.

F[redacted]

Medicals

In order for a medical expense to be assessed against the employer, the expense must be both reasonable and necessary. *Parnell v. Capitol Hill Masonry*, 11 BRBS 532, 539 (1979). Medical care must be appropriate for the injury. 20 C.F.R. § 702.402. A Claimant has established a *prima facie* case for compensable medical treatment where a qualified physician indicates treatment was necessary for a work-related condition. *Turner v. Chesapeake & Potomac Tel. Co.*, 16 BRBS 255, 257-58 (1984). The Claimant must establish that the medical expenses are related to the compensable injury. *Pardee v. Army & Air Force Exch. Serv.*, 13 BRBS 1130 (1981); *Suppa v. Lehigh Valley R.R. Co.*, 13 BRBS 374 (1981). The employer is liable for all medical expenses which are the natural and unavoidable result of the work injury, and not due to an intervening cause. *Atl. Marine v. Bruce*, 661 F.2d 898, 14 BRBS 63 (5th Cir. 1981).

An employee cannot receive reimbursement for medical expenses under this subsection unless he has first requested authorization, prior to obtaining treatment, except in cases of emergency or refusal/neglect. 20 C.F.R. § 702.421; *Shahady v. Atlas Tile & Marble Co.*, 682 F.2d 968 (D.C. Cir. 1982); *McQuillen v. Horne Bros., Inc.*, 16 BRBS 10 (1983); *Jackson v. Ingalls Shipbuilding Div., Litton Sys.*, 15 BRBS 299 (1983); *Schoen v. United States Chamber of Commerce*, 30 BRBS 112 (1996). If an employer has no knowledge of the injury, it cannot be said to have neglected to provide treatment, and the employee therefore is not entitled to reimbursement for any money spent before notifying the employer. *McQuillen*, 16 BRBS 10.

Section 7(c)(2) of the Act provides that when the employer or carrier learns of its employee's injury, it must authorize medical treatment by the employee's chosen physician. Once a Claimant has made his initial, free choice of a physician, he may change physicians only upon obtaining prior written approval of the employer, carrier, or District Director. *See* 33 U.S.C. § 907(c); 20 C.F.R. § 702.406. The employer is ordinarily not responsible for the payment of medical benefits if a Claimant fails to obtain the required authorization. *Slattery Assocs. V. Lloyd*, 725 F.2d 780, 787, 16 BRBS 44, 53 (D.C. Cir. 1984); *Swain v. Bath Iron Works Corp.*, 14 BRBS 657, 664 (1982). Failure to obtain authorization for a change can be excused, however, where the Claimant has been effectively refused further medical treatment. *Lloyd*, 725 F.2d at 787, 16 BRBS at 53; *Swain*, 14 BRBS at 664.

In the present case, Employer/Carrier paid Claimant's medical expenses, including those expenses related to his psychological treatment, until November 2007. (Tr. 7). Since that time, Claimant has incurred hundreds of dollars in bills from doctors' visits and paid out-of-pocket for many prescriptions. (CX-7; CX-9; CX-13). Additionally, Carrier has denied authorization of a sleep study recommended by both Drs. Brinkman and Hubbard, and Dr. Cooke has recommended further surgery for Claimant's left knee. (CX-6, p. 3; CX-11; EX-12, pp. 330, 335). Because I found that Claimant's leg injury and psychological condition were compensable injuries that were caused in the course and scope of his employment with Employer, Employer/Carrier are responsible for all medical expenses that are necessary, reasonable and related to treatment of these conditions.

Regarding his leg injury, Claimant is requesting payment and reimbursement of medical bills owed to and prescriptions written by Dr. Cooke, as well as authorization for surgery to his left knee. In this case, the outstanding medical bills and prescription medications are all related to treatment of Claimant's left leg, and since Employer/Carrier offers no evidence to dispute their necessity or reasonableness, I find these to be the responsibility of Employer/Carrier. As for the knee surgery, it was recommended by Dr. Cooke, the same treating physician who has been monitoring Claimant's leg injury since a few weeks after it occurred. Furthermore, Dr. Cooke indicated that the recommended surgery was related to Claimant's April 8, 2004 injury by initially ruling out latent infection, which was a major concern at the beginning of his treatment, and then by noting that Claimant had failed to respond to conservative treatment. (CX-12, pp. 2, 4-5). Therefore, I find that the arthroscopic knee surgery recommended by Dr. Cooke is also reasonable, necessary and related to Claimant's April 8, 2004 work-related injury.

In regards to Claimant's psychological condition, on June 12, 2006, Dr. Hubbard wrote that Claimant would need continuing treatment, in the form of both counseling and medication, for his PTSD, which was related to his April 8, 2004 injury. (CX-3, p. 2). Therefore, I find that the visits with Drs. Brinkman and Hubbard and the sleep study and medication prescribed by Dr. Hubbard are necessary, reasonable and related to Claimant's April 8, 2004 work-related injury, and therefore are the responsibility of Employer/Carrier.

F[redacted]

ORDER

It is hereby **ORDERED, ADJUDGED and DECREED** that:

(1) Employer/Carrier shall pay to Claimant compensation for temporary total disability benefits for his knee injury and PTSD from April 8, 2004 and continuing based on an average weekly wage of $1,054.81;

(2) Employer/Carrier shall pay or reimburse Claimant for all Section 7 reasonable and necessary past and future medical expenses resulting from Claimant's April 8, 2004 leg injury and PTSD, including medical appointments with Drs. Cooke, Brinkman and Hubbard, medications prescribed by Drs. Cooke and Hubbard, the sleep study recommended by Dr. Hubbard, and the knee surgery recommended by Dr. Cooke;

(3) Employer/Carrier shall be entitled to a credit for all payments of compensation previously made to Claimant;

(4) Employer/Carrier shall pay interest on all of the above sums determined to be in arrears as of the date of service of this ORDER at a rate provided by in 28 U.S.C. §1961;

(5) Claimant's counsel shall have twenty (20) days from receipt of this ORDER in which to file a fully supported attorney fee petition and simultaneously to serve a copy on opposing counsel. Thereafter, Employer/Carrier shall have ten (10) days from receipt of the fee petition in which to file a response;

(6) All computations of benefits and other calculations which may be provided for in this ORDER are subject to verification and adjustment by the District Director.

Entered this 2nd day of December, 2008, at Covington, Louisiana.

C. RICHARD AVERY
Administrative Law Judge

F[redacted]

CERTIFICATE OF FILING AND SERVICE

I certify that the on December 4, 2008 foregoing Compensation Order was filed in the Office of the District Director, Eighth Compensation District, and a copy thereof was mailed on said date by certified mail to the parties and their representative at the last known address of each as follows:

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8144 Walnut Hill Ln. Suite1700
Dallas, TX 75231

A copy was also mailed by regular mail to the following:

Office of Administrative Law Judges
U. S. Department of Labor
428 E. Boston Street, 1st Floor
Covington, LA 70433-2846

Midani, Hinkle & Cole
10497 Town & Country Way
Suite 530
Houston, TX 77024-1117

Wilson Elser Moskowitz Edelman & Dicker, LLP
5847 San Felipe, Suite 2300
Houston, TX 77057-4033

BRADLEY T. SOSHEA
District Director
Eighth Compensation District
U S DOL/ESA/OWCP/LHWCA

Mailed: December 4, 2008 bh

If any compensation, payable under the terms of an award, is not paid within ten days after it becomes due, there shall be added to such unpaid compensation an amount equal to 20 percent thereof. The additional amount shall be paid at the same time as, but in addition to, such compensation.

The date compensation is due is the date the District Director files the decision or order in his office.

AIG WorldSource®

FACSIMILE

DATE: February 5, 2009

TO: Dr. Cooke
C/O Jeannie
325-673-0856
Page 1 of 1 including cover
Tel: [redacted]
Fax: (214) [redacted]-8834

phone 214-758-330

758

FROM: Linda Webb
AIG WorldSource – Foreign Claims
600 N. Pearl Street, Suite 700
Dallas, TX 75201

RE: Claim Number D900-30046
Insured SEH
Claimant Kevin Smith-Idol
Date of Loss 04/08/04

Dear Dr. Cook,

We have received a call from Jeannie requesting authorization for surgery to the left knee of the above captioned claimant. I have requested the current medical and Jeannie is in the process of faxing this information to me.

Our records show that the last MRI to the left knee was completed in April 2008. Prior to the requested surgery being performed, we would like to request that a repeat MRI be completed at the carriers expense.

Please advise as to whether the MRI will be done and if so, please provide us with the date and time.

Thank you for your assistance.

Sincerely,

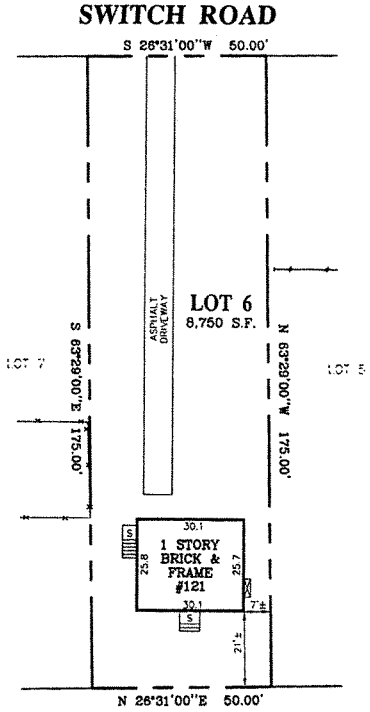
MRI

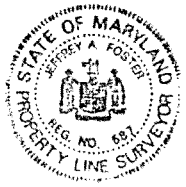
Linda Webb
Senior Examiner
linda.webb@aig.com

[redacted]

717-9

Notes:
1. Flood zone "X" per H.U.D. panel No. 00193D.
2. Setback distances as shown to the principal structure from property lines are approximate. The level of accuracy for this drawing should be taken to be no greater than plus or minus 2 feet. No property corners confirmed. Fences, if shown, have been located by approximate methods.





LOCATION DRAWING
LOT 6, BLOCK 1, SECTION 3
WASHINGTON GROVE
MONTGOMERY COUNTY, MARYLAND

SURVEYOR'S CERTIFICATE	REFERENCES	SNIDER & ASSOCIATES LAND SURVEYORS
"THE INFORMATION SHOWN HEREON HAS BEEN BASED UPON THE RESULTS OF A FIELD INSPECTION PURSUANT TO THE DEED OR PLAT OF RECORD. EXISTING STRUCTURES SHOWN HAVE BEEN FIELD LOCATED BASED UPON MEASUREMENTS FROM PROPERTY MARKERS FOUND OR FROM EVIDENCE OF LINES OF APPARENT OCCUPATION."	PLAT BK. 1 PLAT NO. 22	20270 Goldenrod Lane, Suite 110 Germantown, Maryland 20876 301/948-5100 Fax 301/948-1286
Jeffrey A. Foster 5/27 MARYLAND PROPERTY LINE SURVEYOR REG. NO. 587	LIBER FOLIO	DATE OF LOCATIONS: WALL CHECK: HSE. LOC.: 6-9-09 / SCALE: 1" = 30' / DRAWN BY: J.T.H. / JOB NO.: 09-02365

Employer/Carrier do not even raise the issue on rebuttal. Furthermore, Employer/Carrier fail to offer any medical evidence suggesting that Claimant's PTSD is not related to his injury of April 8, 2004. Overall, I conclude that Claimant's PTSD resulted from his injury of April 8, 2004, and is therefore a compensable injury.

Nature and Extent

Having established an injury, the burden now rests with Claimant to prove the nature and extent of his disability. *Trask v. Lockheed Shipbuilding Constr. Co.*, 17 BRBS 56, 59 (1985). A Claimant's disability is permanent in nature if he has any residual disability after reaching maximum medical improvement. *Id.* at 60. Any disability before reaching MMI would thus be temporary in nature.

The date of maximum medical improvement (MMI) is defined as the date on which the employee has received the maximum benefit of medical treatment such that his condition will not improve. The date on which a Claimant's condition has become permanent is primarily a medical determination. *Mason v. Bender Welding & Mach. Co.*, 16 BRBS 307, 309 (1984). The date of maximum medical improvement is a question of fact based upon the medical evidence of record regardless of economic or vocational consideration. *La. Ins. Guaranty Ass'n v. Abott*, 40 F.3d 122, 29 BRBS 22 (5th Cir. 1994); *Ballesteros v. Willamette Western Corp.*, 20 BRBS 184, 186 (1988); *Williams v. Gen. Dynamics Corp.*, 10 BRBS 915 (1979).

In the present case, Claimant's treating orthopedic physician, Dr. Cooke, placed Claimant's left leg injury at MMI on May 6, 2005.[5] (EX-12, pp. 301-302). On September 2, 2005, Dr. Singleton concurred with Dr. Cooke and determined that Claimant was entitled to a 26 percent impairment rating for his left lower extremity. (EX-12, pp. 327, 339). As for Claimant's psychological condition, Dr. Brinkman placed Claimant at MMI on October 3, 2005, and gave him a psychological impairment rating of 12 percent. (EX-12, pp. 341, 349).

[5] Employer/Carrier argue that Claimant reached MMI on March 24, 2005, based on a statement made by Dr. Gullett that he could see no reason why Claimant would not be able to qualify for a first class aviation medical certification, which Claimant had shown an interest in pursuing. (EX-12, p. 277). However, this offhand statement in regards to Claimant's physical abilities is no substitute for a medical opinion as to the permanency of his leg injury.

Despite these MMI determinations, Claimant's conditions, both orthopedic and psychological, continue to necessitate treatment. On July 23, 2008, Dr. Cooke recommended that Claimant undergo another surgery in order to address his knee condition. (CX-13, pp. 4-5). As for Claimant's psychological condition, on June 12, 2006, Dr. Hubbard opined that Claimant would continue to need psychological counseling and medical intervention to address his PTSD, and he recommended rehabilitation. (CX-3, p. 2). In both instances, Employer/Carrier denied the additional recommended treatment. However, this recent medical evidence indicates to me that both Claimant's knee and PTSD continue to require treatment with a view toward improving both conditions; therefore, I find that Claimant has not reached MMI on either his leg injury or his psychological condition.

The question of extent of disability is an economic as well as medical concept. *Quick v. Martin*, 397 F.2d 644 (D.C. Cir. 1968); *Eastern S.S. Lines v. Monahan*, 110 F.2d 840 (1st Cir. 1940). A Claimant who shows he is unable to return to his former employment due to his work related injury establishes a *prima facie* case of disability. The burden then shifts to the employer to show the existence of suitable alternative employment. *P & M Crane Co. v. Hayes*, 930 F.2d 424, 420, 24 BRBS 116 (5th Cir. 1991); *New Orleans (Gulfwide) Stevedores v. Turner*, 661 F.2d 1031, 1038, 14 BRBS 1566 (5th Cir. 1981). Furthermore, a Claimant who establishes an inability to return to his usual employment is entitled to an award of total disability compensation until the date on which the employer demonstrates the availability of suitable alternative employment. *Rinaldi v. Gen. dynamics Corp.*, 25 BRBS 128 (1991). If the employer demonstrates the availability of realistic job opportunities, the employee's disability is partial, not total. *Southern v. Farmer's Export Co.*, 17 BRBS 24 (1985). Issues relating to nature and extent do not benefit from the Section 20(a) presumption. The burden is upon Claimant to demonstrate continuing disability, whether temporary or permanent, as a result of his accident.

In this case, Claimant's leg injury has precluded him from returning to his previous job with Employer. According to Claimant, part of his job duties included lifting at least 100 pounds and loading freight, which sometimes required climbing onto the truck to strap and tarp it down. (EX-12, pp. 252, 279). On March 28, 2005, Claimant completed his first FCE, which determined that he was able to lift at a medium/heavy level; however, there was concern that he would not

be able to withstand the positional tolerance required by work at that level. (EX-12, p. 279). The FCE demonstrated that Claimant was not physically able to perform those duties required by his previous employment, but there was a possibility he could progress to that point through work conditioning. (EX-12, p. 280).

Nevertheless, after fifteen sessions of occupational therapy, Claimant's physical capabilities still fell short of those required by his former job. The occupational therapist working with Claimant concluded that he was unable to return to his former employment, but he would be able to work in a modified position, one that did not require climbing, walking on uneven surfaces, squatting, or frequent lifting of 100 pounds or more. (EX-12, p. 299).

Claimant's second FCE, performed on September 9, 2005, also demonstrated that he was unable to return to his previous employment. (EX-12, p. 331). It indicated that Claimant could lift up to 70 pounds and carry 45 pounds frequently, but he experienced pain when squatting, kneeling, crouching, and climbing stairs or ladders. Claimant was unable to crawl or put any pressure on his left knee. (EX-12, pp. 332-333). These results are inconsistent with the duties of his former job. Therefore, I find that Claimant's leg injury prevented him from returning to his former employment.

In regards to Claimant's psychological condition, on June 12, 2006, Dr. Hubbard opined that Claimant was unable to return to work due to his PTSD. (CX-3, p. 2). The following day, Dr. Brinkman came to the same conclusion, and specifically wrote that Claimant could not return to his former employment. (CX-1). Both doctors were uncertain as to when Claimant would be able to work. (CX-1; CX-3, p.2). In light of these medical opinions, I also find Claimant's psychological condition precludes him from resuming his previous employment.

To establish suitable alternative employment, an employer must show the existence of realistically available job opportunities within the claimant's geographical area which he is capable of performing, considering his age, education, work experience and physical restrictions, for which the claimant is able to compete and could likely secure if he diligently tried. *New Orleans (Gulfwide) Stevedores v. Turner*, 661 F.2d 1031, 1042-43, 14 BRBS 156, 164-65 (5th Cir. 1981).

Turner does not require that the employer find specific jobs for the claimant or act as an employment agency for the claimant; rather, the employer may simply demonstrate the availability of general job openings in certain fields in the surrounding community. *P & M Crane Co. v. Hayes*, 930 F.2d 424, 431 (5th Cir. 1991); *Avondale Shipyards, Inc. v. Guidry*, 967 F.2d 1039, 1044 (5th Cir. 1992). However, for job opportunities to be realistic, the employer must establish the precise nature and terms of job opportunities which it contends constitute suitable alternative employment. *Thompson v. Lockheed Shipbuilding & Constr. Co.*, 21 BRBS 94, 97 (1988). The administrative law judge must compare the jobs' requirements identified by the vocational expert with the claimant's physical and mental restrictions based on the medical opinions of record. *Villasenor v. Marine Maint. Indus., Inc.*, 17 BRBS 99, 103 (1985). Once the employer demonstrates the existence of suitable alternative employment, the claimant can nonetheless establish total disability by demonstrating that he tried with reasonable diligence to secure such employment and was unsuccessful. *P & M Crane Co.*, 930 F.2d at 430.

In the present case, Employer/Carrier argue that they have met the burden of establishing suitable alternate employment because Claimant resumed working as a truck driver for a different employer in February 2008. (Tr. 20, 24, 29). However, the fact that a claimant works after an injury does not always preclude a finding of total disability. *Haughton Elevator Co. v. Lewis*, 572 F.2d 447 (4th Cir. 1978). One situation in which a claimant will be found totally disabled despite returning to work after his injury occurs when he continues his employment through extraordinary effort and despite considerable pain and diminished strength. *Id.* The Board has cautioned against broad application of these cases and emphasized that these circumstances are the exception and not the rule. *Chase v. Bethlehem Steel Corp.*, 9 BRBS 143 (1978).

Both doctors treating Claimant for his PTSD opined that Claimant would be unable to return to work for eight hours a day, and that he was unable to return to his former employment. (CX-1; CX-3, p. 2). Yet without revealing his medications, Claimant sought and obtained a job as a truck driver hauling heavy equipment, working approximately 42 hours a week, in order to make money to support his family. (Tr. 20, 24, 29). The medications he takes for his PTSD affect his job performance by making him drowsy, and he has to pull over several times a day to take naps, all of which he knows makes it unsafe for him to work as a truck driver. (Tr. 25). Likewise, the pharmacy has flagged some of these medications for being high dosages. (CX-12, p. 1).

F[redacted]

Furthermore, Claimant's return to work coincided with a return of his left knee symptoms. Claimant returned to see Dr. Cooke for pain and swelling in his left knee on March 5, 2008, almost two years after his previous appointment. (CX-13, p. 2). On a subsequent visit, on April 1, 2008, Claimant was experiencing spasms, cramps, popping, grinding and catching in his knee. He described his pain as constant and severe, and stated that his limping would worsen during the day, to the point that he was unable to do much of anything after his workday. (CX-13, pp. 2-3). Claimant was glad to get back to work, but stated that many of the activities involved left him in great physical pain. (CX-6, p. 3). Dr. Cooke ordered an MRI, and on July 23, 2008, recommended that Claimant undergo further surgery to address his knee problems. (CX-13, pp. 3-5).

In sum, despite warnings from the doctors treating his PTSD that he should not return to work, and despite a recurrence of severe knee pain, Claimant returned to work as a truck driver to support his family. I find that Claimant has shown extraordinary effort in returning to work against the recommendations of his treating physicians and in spite of considerable physical pain. Therefore, despite his return to work, Claimant continues to be totally disabled.[6]

Average Weekly Wage

Section 10 sets forth three alternative methods for determining a claimant's average annual earnings, which are then divided by fifty-two, pursuant to Section 10(d), to arrive at an average weekly wage. 33 U.S.C. § 910(d)(1). The computation methods are directed towards establishing a claimant's earning power at the time of the injury. *Johnson v. Newport News Shipbuilding & Dry Dock Co.*, 25 BRBS 340 (1992); *Lobus v. I.T.O. Corp.*, 24 BRBS 137 (1990).

Sections 10(a) and 10(b) apply to an employee working full-time in the employment in which he was injured. *Roundtree v. Newpark Shipbuilding & Repair, Inc.*, 13 BRBS 862 (1981), *rev'd* 698 F.2d 743, 15 BRBS 94 (CRT) (5th Cir. 1983), *panel decision rev'd en banc*, 723 F.2d 399, 16 BRBS 34 (CRT) (5th Cir.) *cert. denied*, 469 U.S. 818 (1984). Section 10(a) applies if the employee worked "substantially the whole of the year" preceding the injury, which refers to the nature of the employment, not necessarily the duration. The inquiry should

[6] Employer/Carrier point out that on March 12, 2008, Dr. Brinkman became aware of Claimant's return to work yet failed to assign any restrictions. While Dr. Brinkman did in fact acknowledge Claimant's return to work, he identified it as evidence of Claimant's efforts to overcome his PTSD symptoms. Dr. Brinkman never indicated any intent to withdraw his opinion that Claimant should not return to work; in fact, he noted that Claimant's PTSD symptoms were interfering with his new job duties. (EX-12, p. 409).

focus on whether the employment was intermittent or permanent. *Gilliam v. Addison Crane Co.*, 21 BRBS 91 (1987); *Eleazer v. General Dynamics Corp.*, 7 BRBS 75 (1977). If the time in which the claimant was employed was permanent and steady then Section 10 (a) should apply. *Duncan v. Washington Metropolitan Area Transit*, 24 BRBS 133 (1990) (holding that 34.5 weeks of work was "substantially the whole year," where the work was characterized as "full time," "steady" and "regular"). The number of weeks worked should be considered in tandem with the nature of the work when deciding whether the Claimant worked substantially the whole year. *Lozupone v. Lozupone & Sons*, 12 BRBS 148, 153-156 (1979).

Section 10(b) applies to an injured employee who worked in permanent or continuous employment, but did not work for substantially the whole year. 33 U.S.C. § 910(b); *Empire United Stevedores v. Gatlin*, 936 F.2d 819, 25 BRBS 26 (CRT)(5th Cir. 1991). This would be the case where the Claimant had recently been hired after having been unemployed. Section 10(b) looks to the wages of other workers and directs that the average weekly wage should be based on the wages of an employee of the same class, who worked substantially the whole of the year preceding the injury, in the same or similar employment, in the same or neighboring place. Accordingly, the record must contain evidence of the substitute employee's wages. *See Sproull v. Stevedoring Servs. of America*, 25 BRBS 100, 104 (1991).

Both Sections 10(a) and 10(b) apply to an employee who worked five or six days a week. Because Claimant worked for Employer for seven days a week, both Sections 10(a) and 10(b) are inappropriate methods for determining Claimant's average weekly wage. (EX-2).

Section (c) is a catch-all to be used in instances when neither (a) nor (b) are reasonably and fairly applicable. If employee's work is inherently discontinuous or intermittent, his average weekly wage for purposes of compensation award under Longshore and Harbor Workers' Compensation Act (LHWCA) is determined by considering his previous earnings in employment in which he was working at the time of injury, reasonable value of services of other employees in same or most similar employment, or other employment of employee, including reasonable value of services of employee if engaged in self-employment. Longshore and Harbor Workers' Compensation Act, §§ 10(c), 33 U.S.C.A. §§ 910(c). *New Thoughts Finishing Co. v. Chilton*, 118 F.3d 1028 (5th Cir. 1997)

In this case, I find that Section 910(c) applies because neither (a) nor (b) can be reasonably and fairly used to determine Claimant's average weekly wage. The Administrative Law Judge has broad discretion in determining annual earning capacity under subsection 10(c). *Hayes v. P & M Crane Co., supra*; *Hicks v. Pacific Marine & Supply Co., Ltd.*, 14 BRBS 549 (1981). It should also be stressed that the objective of subsection 10(c) is to reach a fair and reasonable approximation of a claimant's wage-earning capacity at the time of injury. *See Story v. Navy Exch. Serv. Center*, 33 BRBS 111(1999).

One way to calculate Claimant's average weekly wage (AWW) under Section 10(c) is to use his actual earnings with Employer at the time of his injury. However, Employer/Carrier argue that calculating Claimant's AWW using only those wages he earned during the three months he was overseas would fail to represent a reasonable approximation of Claimant's earning capacity at the time of his injury. Instead, Employer/Carrier contend that Claimant's AWW should be determined by combining or blending the wages he earned during the year immediately preceding his accident, including those from Employer and those earned from other employers. In *Meyer v. Service Employees International*, 2005-LDA-77 (Feb. 7, 2006), the ALJ determined that a blended approach would provide a more true earning capacity because it would establish a compromise, and allow the claimant to benefit from higher earnings while recognizing the fact that his employment contract was at-will and only for twelve months of employment.

In this case, I agree with Employer/Carrier and find it appropriate to blend Claimant's higher earnings from Employer with those wages earned stateside during the 52 weeks prior to his injury. Similar to *Meyer*, Claimant's employment in Iraq was subject to an at-will agreement and there was no guarantee his employment would last beyond twelve months. (EX-1, pp. 1-2). Under these circumstances, I find that the most appropriate, fair and reasonable method of computing Claimant's AWW is to take into consideration Claimant's earnings in the year immediately preceding his injury on April 8, 2004.

During the 52 weeks preceding his April 8, 2004 injury, Claimant worked for three different employers. From April 11, 2003 until October 15, 2003, Claimant earned $22,828.57 from Delta Metals. From October 2003 until his employment in Iraq, Claimant earned $10,564.29 from TWI. While working overseas for Employer from January 11, 2004 to April 8, 2004, Claimant earned $21,457.25. (EX-10, p. 1). Overall, from April 11, 2003 until April 8, 2004, Claimant earned a total of $54,850.11, which when divided by 52 weeks equals an AWW of $1,054.80.

F[redacted]

Medicals

In order for a medical expense to be assessed against the employer, the expense must be both reasonable and necessary. *Parnell v. Capitol Hill Masonry*, 11 BRBS 532, 539 (1979). Medical care must be appropriate for the injury. 20 C.F.R. § 702.402. A Claimant has established a *prima facie* case for compensable medical treatment where a qualified physician indicates treatment was necessary for a work-related condition. *Turner v. Chesapeake & Potomac Tel. Co.*, 16 BRBS 255, 257-58 (1984). The Claimant must establish that the medical expenses are related to the compensable injury. *Pardee v. Army & Air Force Exch. Serv.*, 13 BRBS 1130 (1981); *Suppa v. Lehigh Valley R.R. Co.*, 13 BRBS 374 (1981). The employer is liable for all medical expenses which are the natural and unavoidable result of the work injury, and not due to an intervening cause. *Atl. Marine v. Bruce*, 661 F.2d 898, 14 BRBS 63 (5th Cir. 1981).

An employee cannot receive reimbursement for medical expenses under this subsection unless he has first requested authorization, prior to obtaining treatment, except in cases of emergency or refusal/neglect. 20 C.F.R. § 702.421; *Shahady v. Atlas Tile & Marble Co.*, 682 F.2d 968 (D.C. Cir. 1982); *McQuillen v. Horne Bros., Inc.*, 16 BRBS 10 (1983); *Jackson v. Ingalls Shipbuilding Div., Litton Sys.*, 15 BRBS 299 (1983); *Schoen v. United States Chamber of Commerce*, 30 BRBS 112 (1996). If an employer has no knowledge of the injury, it cannot be said to have neglected to provide treatment, and the employee therefore is not entitled to reimbursement for any money spent before notifying the employer. *McQuillen*, 16 BRBS 10.

Section 7(c)(2) of the Act provides that when the employer or carrier learns of its employee's injury, it must authorize medical treatment by the employee's chosen physician. Once a Claimant has made his initial, free choice of a physician, he may change physicians only upon obtaining prior written approval of the employer, carrier, or District Director. *See* 33 U.S.C. § 907(c); 20 C.F.R. § 702.406. The employer is ordinarily not responsible for the payment of medical benefits if a Claimant fails to obtain the required authorization. *Slattery Assocs. V. Lloyd*, 725 F.2d 780, 787, 16 BRBS 44, 53 (D.C. Cir. 1984); *Swain v. Bath Iron Works Corp.*, 14 BRBS 657, 664 (1982). Failure to obtain authorization for a change can be excused, however, where the Claimant has been effectively refused further medical treatment. *Lloyd*, 725 F.2d at 787, 16 BRBS at 53; *Swain*, 14 BRBS at 664.

In the present case, Employer/Carrier paid Claimant's medical expenses, including those expenses related to his psychological treatment, until November 2007. (Tr. 7). Since that time, Claimant has incurred hundreds of dollars in bills from doctors' visits and paid out-of-pocket for many prescriptions. (CX-7; CX-9; CX-13). Additionally, Carrier has denied authorization of a sleep study recommended by both Drs. Brinkman and Hubbard, and Dr. Cooke has recommended further surgery for Claimant's left knee. (CX-6, p. 3; CX-11; EX-12, pp. 330, 335). Because I found that Claimant's leg injury and psychological condition were compensable injuries that were caused in the course and scope of his employment with Employer, Employer/Carrier are responsible for all medical expenses that are necessary, reasonable and related to treatment of these conditions.

Regarding his leg injury, Claimant is requesting payment and reimbursement of medical bills owed to and prescriptions written by Dr. Cooke, as well as authorization for surgery to his left knee. In this case, the outstanding medical bills and prescription medications are all related to treatment of Claimant's left leg, and since Employer/Carrier offers no evidence to dispute their necessity or reasonableness, I find these to be the responsibility of Employer/Carrier. As for the knee surgery, it was recommended by Dr. Cooke, the same treating physician who has been monitoring Claimant's leg injury since a few weeks after it occurred. Furthermore, Dr. Cooke indicated that the recommended surgery was related to Claimant's April 8, 2004 injury by initially ruling out latent infection, which was a major concern at the beginning of his treatment, and then by noting that Claimant had failed to respond to conservative treatment. (CX-12, pp. 2, 4-5). Therefore, I find that the arthroscopic knee surgery recommended by Dr. Cooke is also reasonable, necessary and related to Claimant's April 8, 2004 work-related injury.

In regards to Claimant's psychological condition; on June 12, 2006, Dr. Hubbard wrote that Claimant would need continuing treatment, in the form of both counseling and medication, for his PTSD, which was related to his April 8, 2004 injury. (CX-3, p. 2). Therefore, I find that the visits with Drs. Brinkman and Hubbard and the sleep study and medication prescribed by Dr. Hubbard are necessary, reasonable and related to Claimant's April 8, 2004 work-related injury, and therefore are the responsibility of Employer/Carrier.

F[redacted]

ORDER

It is hereby **ORDERED, ADJUDGED** and **DECREED** that:

(1) Employer/Carrier shall pay to Claimant compensation for temporary total disability benefits for his knee injury and PTSD from April 8, 2004 and continuing based on an average weekly wage of $1,054.81;

(2) Employer/Carrier shall pay or reimburse Claimant for all Section 7 reasonable and necessary past and future medical expenses resulting from Claimant's April 8, 2004 leg injury and PTSD, including medical appointments with Drs. Cooke, Brinkman and Hubbard, medications prescribed by Drs. Cooke and Hubbard, the sleep study recommended by Dr. Hubbard, and the knee surgery recommended by Dr. Cooke;

(3) Employer/Carrier shall be entitled to a credit for all payments of compensation previously made to Claimant;

(4) Employer/Carrier shall pay interest on all of the above sums determined to be in arrears as of the date of service of this ORDER at a rate provided by in 28 U.S.C. §1961;

(5) Claimant's counsel shall have twenty (20) days from receipt of this ORDER in which to file a fully supported attorney fee petition and simultaneously to serve a copy on opposing counsel. Thereafter, Employer/Carrier shall have ten (10) days from receipt of the fee petition in which to file a response;

(6) All computations of benefits and other calculations which may be provided for in this ORDER are subject to verification and adjustment by the District Director.

Entered this 2nd day of December, 2008, at Covington, Louisiana.

C. RICHARD AVERY
Administrative Law Judge

F[redacted]

CERTIFICATE OF FILING AND SERVICE

I certify that the on December 4, 2008 foregoing Compensation Order was filed in the Office of the District Director, Eighth Compensation District, and a copy thereof was mailed on said date by certified mail to the parties and their representative at the last known address of each as follows:

Kevin C Smith-Idol
3117 Melinda Lane
Abilene, TX 79603

Service Employers International
601 Jefferson Street
Room 3536
Houston, TX 77002

Insurance Co. Of The State Of Penn.
c/o Amer. Intl. Underwriters
8144 Walnut Hill Ln. Suite1700
Dallas, TX 75231

A copy was also mailed by regular mail to the following:

Office of Administrative Law Judges
U. S. Department of Labor
428 E. Boston Street, 1st Floor
Covington, LA 70433-2846

Midani, Hinkle & Cole
10497 Town & Country Way
Suite 530
Houston, TX 77024-1117

Wilson Elser Moskowitz Edelman & Dicker, LLP
5847 San Felipe, Suite 2300
Houston, TX 77057-4033

BRADLEY T. SOSHEA
District Director
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U S DOL/ESA/OWCP/LHWCA

Mailed: December 4, 2008 bh

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[redacted]

AIG WorldSource®

FACSIMILE

DATE: February 5, 2009

TO: Dr. Cooke
C/O Jeannie
325-673-0856
Page 1 of 1 including cover
Tel: [redacted]
Fax (214) [redacted]-8834

Phone 214-758-330

758

FROM: Linda Webb
AIG WorldSource – Foreign Claims
600 N. Pearl Street, Suite 700
Dallas, TX 75201

RE: Claim Number D900-30046
Insured SEII
Claimant Kevin Smith-Idol
Date of Loss 04/06/04

Dear Dr. Cook,

We have received a call from Jeannie requesting authorization for surgery to the left knee of the above captioned claimant. I have requested the current medical and Jeannie is in the process of faxing this information to me.

Our records show that the last MRI to the left knee was completed in April 2008. Prior to the requested surgery being performed, we would like to request that a repeat MRI be completed at the carriers expense.

Please advise as to whether the MRI will be done and if so, please provide us with the date and time.

Thank you for your assistance.

Sincerely,

MRI

Linda Webb
Senior Examiner
linda.webb@aig.com

[redacted]

717.9

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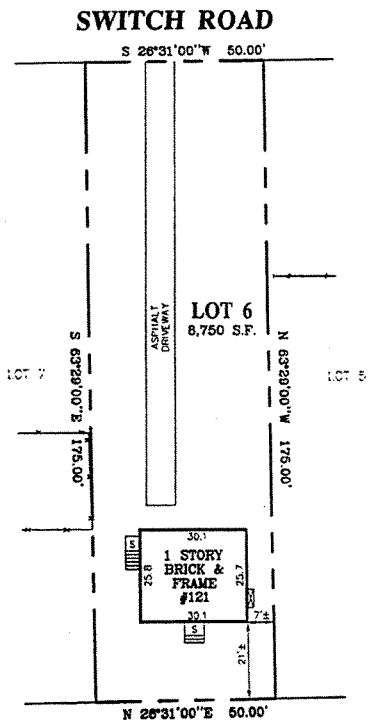

LOCATION DRAWING
LOT 6, BLOCK 1, SECTION 3
WASHINGTON GROVE
MONTGOMERY COUNTY, MARYLAND

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Jeffrey A. Foster 567 MARYLAND PROPERTY LINE SURVEYOR REG. NO. 567	LIBER FOLIO	DATE OF LOCATIONS WALL CHECK: HSE. LOC.: 6-9-09
		SCALE: 1" = 30' DRAWN BY: J.T.H. JOB NO.: 09-02385

Mr. KUCINICH. I thank Mr. Smith. The Chair recognizes Mr. Woodson for 5 minutes. I would just ask you to make sure that mic is close to you so we can hear your testimony.

STATEMENT OF JOHN WOODSON

Mr. WOODSON. My two colleagues here have covered quite a bit here and said a lot. Thank you all for having me here, having all of us here. I would like to thank each and every one of you for inviting me today to share my experiences with you.

My name is John Woodson. Prior to going to Iraq, I was a construction supervisor in Houston, TX working with cranes in the rigging industry. I worked in the aerospace, commercial, and petrochemical fields, investing 25 years of my life.

In late 2003, KBR representatives contacted me asking if I had thoughts about going to Iraq and helping to rebuild the country. To me, that was a great opportunity to provide my contribution to this country so I left in June 2004 to go to Iraq. Unfortunately, I was blown up by an IED blast on October 28, 2004. Now, here we are in June 2009, 5 years later, and I am still wondering why events have happened the way they have.

After waking up from a medically induced coma at the Methodist Hospital in Houston, TX, I was sent to a rehabilitation facility called TIRR. There I was visited by James Hile from AIG. He was a representative, adjuster, and investigator working for AIG Insurance. After seeing my condition, he stated that there wouldn't be any problem because AIG was going to take care of my life and everything involved. That statement shortly turned out to be untrue because the first problem quickly arose.

The first problem was my money. Nothing was being deposited into my account. My wife, brother, and daughter then spoke with Mr. Hile about the issue. He told them that the situation would be looked into. Several weeks later, I did receive a deposit but the weekly average was lower than what had been spoken about.

At that point I called AIG Insurance and spoke to Jim McIntire, who refused to talk to me. He flatly said to me, "hire an attorney and AIG will discuss the issue with them." At first, I wanted to believe that it was just a small misunderstanding because it was a new account. But the reality soon sank in.

The result would be larger than I could even imagine. The conflict that started then is still going on today. Every aspect is a disagreement, a complex and infinite process from medical, money, pharmaceuticals, and transportation standpoints. Even the Department of Labor in Houston has not been any help. I am just naming a few on the list. It is really too long to write.

Ladies and gentlemen, due to my vision impairment, speaking about this matter would be much easier on me. It would be much more conducive.

As of April 24, 2009, my case has been turned over to the U.S. Government. I still haven't noticed much of an improvement. In conclusion, I ask why. Where has the oversight been? Who is in charge of this operation?

[The prepared statement of Mr. Woodson follows:]

Statement
Of
John Woodson
Former Civilian Contractor Injured in the War Zone

Domestic Policy Subcommittee
Oversight and Government Reform Committee

"After Injury, the Battle Begins: Evaluating Workers' Compensation for Civilian Contractors in War Zones"

2154 Rayburn HOB
Thursday, June 18, 2009
2:00 p.m.

Chairman Kucinich and Ranking Member Jordan and all Subcommittee Members,

I would like to thank you very much for inviting me here today to share my experiences with you. My name is John Woodson. Prior to going to Iraq, I was a Construction Supervisor in Houston, Texas, working with Cranes in the Rigging Industry. I worked Aerospace, Commercial and Petro-Chemical fields investing 25 years of my life.

In late 2003, a KBR Representative contacted me, asking if I had thoughts about going to Iraq and help rebuild the country, which to me was an opportunity to provide my contribution. So, I left in June 2004 to go to Iraq and unfortunately, I was blown up by an I.E.D. blast on October 28, 2004. Now, here we are in June 2009, 5 years later and I am still wondering why events have happened the way they have?

After waking up from a medical induced coma at the Methodist Hospital in Houston, Texas, I was sent to a rehabilitation facility called TIRR. There, I was visited by James Hile from AS&G. He was an

Adjuster/Investigator working for AIG Insurance. After seeing my condition, he stated there wouldn't be any problems because AIG was going to take care of my life and everything else involved, a statement that will shortly turn out to be untrue because the first problem quickly arose.

The first problem was money. Nothing was being deposited into my account. My wife, brother and daughter then spoke with Mr. Hile about the issue. He told them that the situation would be looked into. Several weeks later, I did receive a deposit, but the weekly average was lower than what had been spoken about. At that point, I called AIG Insurance and spoke to Jim McIntire who refused to talk to me, he flatly said to me: "Hire an Attorney and AIG would discuss the issue with them".

At first, I wanted to believe this was just a small misunderstanding because it was a new account, but the reality soon sank in and the result would be larger than I could even imagine. The conflict that started then is still going on today. Every aspect is a disagreement, a complex and indefinite process, from medical, money, pharmaceutical, transportation, even the Department Of Labor in Houston has not been any help, and I am just naming a few, the list is too long to write.

Ladies and Gentlemen, due to my vision impairment, speaking about this would be much more conductive for me. As of April 24, 2009, my case had been turned over to the U.S. Government, and I still haven't noticed much of an improvement.

In conclusion, I ask why? Where has the oversight been? Who is in charge of this operation?

Mr. KUCINICH. Mr. Woodson, thank you very much for your testimony. The Chair recognizes Mr. Pitts.

STATEMENT OF GARY PITTS

Mr. PITTS. Thank you, Chairman Kucinich, Ranking Member Jordan, Congresswoman Watson, and Congressman Cummings. Thank you for starting this process. I thank you for your interest and attention to these brave men and women who go over there and fill in for what the Army used to do.

I have had the opportunity, the privilege, of representing hundreds of them. Based on that experience and on 30 years of operating before the Department of Labor, here are my five recommendations to make this system work more quickly and better:

First of all, there hasn't been any additional funding since the war began for the Office of Workers' Compensation Programs or the Office of Administrative Law Judges. Whereas AIG, for example, had three adjustors in 2004 in Dallas that handle these cases, now they have about 30. That is a tenfold increase. There has been no increase at the Department of Labor.

For example, OALJ could use some video conferencing equipment. That sounds pretty mundane but that could help a lot. It would maybe cost $200,000 to outfit all of them with video conferencing equipment. Right now we have to do a circuit. We are like the old West. We go to the claimant. The judge does, I go, and the defense attorney goes. If we had video conferencing equipment outfitted with the judges, we could have those conferences done more quickly. We could move this process along. It would save money from having to send the judge there and back, and it would save his time.

The second thing I would suggest is that on PTSD, it is taking about a year or a year and a half to work through the system before somebody can get treatment. The Army, in contrast, they tell people what the symptoms are before they leave the theater. They check back up on them 2 or 3 months later. Contractors don't have any of that. They get back, they start having symptoms, their family sends them to get some help, and they enter the process of litigating their case. This is a wasteful system like it is because the litigation costs are eventually going to get put off on the taxpayer. I am trying to work myself out of some work here.

All these people should immediately be able to go to the VA. They are coming out of the war zone. They should just go to the VA. The VA is set up for taking care of PTSD. Just let them go there and get in line with everybody else for the group therapy. There is less chance of them hurting themselves or hurting people around them. That is economical, it is efficient, and it is an exception. There will be some people who say well, they are not in the military so they shouldn't be able to go to the VA. This is an exception. They are right there next to our soldiers. The enemy doesn't distinguish them from our soldiers. If they have PTSD uniquely situated coming from the war zone, just let them go to the VA.

The third thing is there is presently no requirement that, if one of these men is killed over there, that the widow acknowledge that there is such a thing as death benefits or that there is a possibility of death benefits under the act. This applies to the surviving

spouse since there are also ladies over there. That could be easily remedied. Just basically the employer would have the obligation to get a one page acknowledgment from the widow saying I understand there is the possibility that I may be entitled to death benefits under the Defense Base Act. They ought to be able to attach that to their paperwork in order to get paid or they don't get paid by the Government or they don't get a new contract.

This should be able to be enforced quickly so we don't have the anomaly of some lady in a small part of the country with a house full of children and her breadwinner is dead going on Government relief because she hasn't figured out what the Defense Base Act is and how to fill out the right form to file it with a New York office within a year, the statute of limitations. So that is a little gap that could be taken care of.

The fourth thing I would suggest is there is now really no stick for the Administrative Law Judge. Let me point out and make this clear, nobody can make the insurance company do anything except the judge. The Department of Labor has no power to make them do anything. They can give informal recommendations, which we have to have in order to have the case come up to be assigned to one of the 40 or so Administrative Law Judges that hear these cases. But we have to go through this process and litigate these issues in order to get resolution.

Now they will do what the judge tells them to. They have to. Well, we have some problems sometimes even with that. However, the judge is really the only one who can make them do things.

So we can beef up the OALJ. They used to have like 100 judges to do the Black Lung docket. They need some extra ones. You can see from my paper, the trials have gone from 95 in 2005 to about 578 scheduled this year. It is a fivefold increase. They need some help and additional funding.

Anyway, what I am suggesting is the judge needs a stick. At this point, all he can do is make them do what they should have done to begin with, plus they have to pay my time for having held them down and making them do something and they have to pay interest. But it is at short term Treasury rates. So these gentlemen, if they go through litigation and the judge says, like Judge Avery did in Mr. Smith's case, you have to pay this, they also only have to pay like half of 1 percent. That is the interest they have to pay. So the judge should be able assess a 15 percent penalty, a 10 percent penalty, or whatever for a frivolous defense.

In addition, they can profit by 20 C.F.R. 61.104. They can add a 15 percent handling fee for litigating a War Hazards Act claim. So if they are hurt from enemy action, they can profit by litigating it. That needs to change.

[The prepared statement of Mr. Pitts follows:]

Statement
Of
Gary Pitts
Attorney for Civilian Contractors Injured in the War Zone

Domestic Policy Subcommittee
Oversight and Government Reform Committee

"After Injury, the Battle Begins: Evaluating Workers' Compensation for Civilian Contractors in War Zones"

2154 Rayburn HOB
Thursday, June 18, 2009
2:00 p.m.

Good afternoon, Chairman Kucinich and Honorable Members of the Committee. I am an attorney that has practiced before the U.S. Department of Labor for the last 30 years. Since the war began six years ago, I have had the honor of representing more civilian contractors wounded, injured, or ill from the war zone, than any other attorney in the country. I have had over 300 Defense Base Act cases going on at all times for the last four years, from all parts of our country. The most frequent demographic of my clients has been a truck driver hit by a roadside bomb.

On behalf of my clients, and civilian contractors injured in the war zone in general, thank you for your concern for their proper treatment. In regard to the delays in the proper and efficient handling of their cases, I have four proposals, based upon my experience:

1.) **Additional funding of the U.S. Department of Labor's Office of Workers' Compensation Programs ("OWCP') and Office of Administrative Law Judges ("OALJ")**, while the war is going on. The number of Defense Base Act cases and trials has dramatically increased over the course of the war (statistics for trials are listed below). For example, AIG had three adjusters in Dallas handling Defense Base Act cases in mid-2004. They now have about 30, a ten-fold increase, because of the numbers of injured. In contrast, there has been no increase in the number of people working in the two U.S. Department of Labor offices that handle these cases since the war began. Both the Office of Workers' Compensation and the Office of Administrative Law Judges have done a great job with the resources that they have, but they need some additional help while the war continues, so that the cases can be handled in a more efficient and a timely manner.

For example, if the Office of Administrative Law Judges could afford to be

outfitted with video-conferencing equipment (which would probably cost about $200,000 total for all of the Judges), the hearings could be handled more quickly and efficiently. It would reduce the cost to the system in the long run because Judges would not have to waste their time and taxpayer's money to travel to remote locations for the Formal Hearings, and the hearings could be set relatively quickly.

2.) **American contractors coming from the war zone with post-traumatic stress disorder ("PTSD") should be able to obtain treatment at the VA rather than have to litigate their case to get treatment.** Currently, a contractor's case usually takes about a year and a half to work its way through the system and to be litigated to conclusion in order to get any treatment for PTSD. If it is found that the contractor has PTSD from the war, the cost of the litigation (about $30-$40,000 or so - adding both the defense and prosecution costs) gets passed on to the taxpayer through the War Hazards Act. It would be more efficient and humane, and also more economical to the American taxpayer to just let contractors psychologically traumatized by the war to immediately go to the VA for treatment. Research shows that early treatment for PTSD reduces the risk of a life-long problem. Also, the risk of a contractor with PTSD hurting themselves or others before they can get any psychological treatment would be eliminated.

There may be resistance by some, in principle, to letting any non-soldier be seen by the VA for anything; but in the particular instance of PTSD, which the VA has the expertise for in our country, and which is a direct result of violent combat exposures in the war zone, it makes humanitarian and financial sense for all concerned to just let American war zone contractors be seen there rather than have to litigate their case in order to get any treatment for it.

3.) **Requiring an employer to get a written acknowledgment from the widow of a contractor killed in the war zone, that she understands that she and their dependent children may have rights to death benefits under the Defense Base Act.** There is presently no such requirement. Presently if a widow (or surviving spouse) does not figure out that there is such a thing as the Defense Base Act, and how to timely and properly file a claim with the New York office of the OWCP, she and their children may end up destitute and on public assistance. The workers' compensation insurance company would be unjustly enriched in such an instance, by the spouse being kept in the dark, when they have already been paid premiums to pay proper death benefits. Production of the one-page written acknowledgment of the surviving spouse could be a condition of the contract, which would hold up payment by the government on the contract, or be the subject of a statutory fine, if it is not done.

4.) **If there is a judicial finding by a Federal Administrative Law Judge of a frivolous defense, a 10% penalty should be allowed to be assessed.** If a Claimant's claim is frivolous, it will be dismissed, and there are criminal penalties for a Claimant making a fraudulent claim or perjuring themselves. On the other hand, there is currently really no stick available to the Judge if the insurance company exhibits bad behavior. If they lose a

case, the insurance company only has to pay interest on the benefits overdue (presently less than ½ %), and pay Claimant's attorney's time, but otherwise, the Judge can only make them do what they should have done to begin with, even if the insurance company has no actual defense, or they maintain a patently frivolous defense.

There is presently a provision for a 10% penalty for nonpayment, but it is stopped merely by the pro-forma filing of a Notice of Controversion by the insurance company, which is generally done very early in the case. Allowing the Administrative Law Judge to assess the 10% penalty even after a Notice of Controversion is filed, if there is a judicial finding of a frivolous defense beyond the informal conference recommendations, would only require a brief amendment to the penalty provision of the law.

U.S. District Judges, and most state court judges, have the ability to sanction a party for frivolous pleadings. Federal Administrative Law Judges should also be able to assess some penalty where there is clearly an abuse of the system by an insurance company, where there is a judicial finding of a frivolous defense.

Thank you again for your attention to the proper treatment of our civilian contractors injured in the war zone while they are providing the vital support functions that the Army used to have to do for itself.

Number of Defense Base Act cases docketed for trial (Formal Hearing), from Office of Administrative Law Judges statistics:

2005	2006	2007	2008	2009
95	**145**	**359**	**428**	385 - as of 5/30/09, 2/3 of the fiscal yr., so about **578** projected for the year at the current rate

Mr. KUCINICH. Thank you very much, Mr. Pitts. We now hear from General Fay. You may proceed.

STATEMENT OF MAJOR GENERAL GEORGE R. FAY

General FAY. Thank you, Mr. Chairman. Thank you, Ranking Member Jordan and distinguished members of the subcommittee. Thank you for the opportunity to appear before you today on behalf of CNA Insurance. I am George Fay, Executive Vice President of Worldwide Property and Claim for CNA Financial Corp. I have more than 30 years of experience in the insurance industry.

I retired from the U.S. Army Reserves as a major general in May 2008 after 38 years of service, including almost 4 years on active duty in support of the Global War on Terrorism and Operation Iraqi Freedom. During those 4 years, I served in many parts of the world, including Iraq and Afghanistan, side by side with defense contractors in every location.

I share the subcommittee's view that civilian workers in Afghanistan, Iraq, and elsewhere around the world are performing a crucial service for this country and that they deserve fair treatment in the administration of insurance claims. I understand well the sacrifices being made by the men and women who support our military operations abroad. I am pleased to be part of the CNA family that takes great pride in supporting those that make such great sacrifices.

CNA understands that this hearing focuses on two categories of concern under the Defense Base Act, claims handling and underwriting gains.

With regard to claims handling, I would like to address some errors that were made in the majority staff's June 16, 2009 memorandum addressed to the subcommittee. The memorandum implies that CNA has a record of unnecessarily pushing claims to administrative rulings. This is misleading. In fact, of the approximately 5,500 claims that have been filed, CNA believes that fewer than 20 of those claims, less than 0.4 percent, have gone to administrative rulings. Of those cases, CNA has lost only a handful. Even in the cases that CNA has lost, there was never a finding that CNA acted in bad faith or advocated frivolous positions.

CNA's experience is consistent with the written statement of Seth Harris, who you just heard from before as the Deputy Secretary of the Department of Labor. It noted that the DOL has found no deliberate intent to delay claims handling. His statement is borne out by the numbers I have set forth in my written statement.

We are contacting insured workers and their companies within 24 hours 86 percent of the time. Despite the strict, we believe too strict, requirement to make a compensability determination within 14 days, we have been able to make that determination within those 14 days 75 percent of the time.

Related to the underwriting concern, it should be noted that the overall CNA DBA underwriting gain from 2002 to 2008 was only 14 percent. Moreover, CNA's role in the at large part of the business on which the subcommittee is focusing today has been minuscule since 2006 with only about 3 percent of the market share.

In contrast, CNA is currently the only provider of the widely praised program contracts which are awarded through a bidding process. In 2008, Chairman Waxman lauded this process and highlighted CNA's presence in the market. We concur with those who suggest that the program contracts are the solution to the DBA underwriting concerns.

CNA would be happy to work with the subcommittee to improve the process governing DBA contracts. Therefore, Mr. Chairman, I thank you for the opportunity to discuss these issues today. I would be pleased to answer any questions that the subcommittee has.

[The prepared statement of General Fay follows:]

Statement
Of
Major General George R. Fay
Executive Vice President,
Worldwide Property and Casualty Claim
CNA Financial Corporation

Domestic Policy Subcommittee
Oversight and Government Reform Committee

"After Injury, the Battle Begins: Evaluating Workers' Compensation for Civilian Contractors in War Zones"

Thursday, June 18, 2009
2154 Rayburn HOB
2:00 p.m.

Chairman Kucinich, Ranking Member Jordan, Senator Sanders, and distinguished members of the Subcommittee, thank you for the opportunity to appear before you today on behalf of CNA Insurance and, specifically, to address CNA's handling of the insurance claims process for civilian contractors under the Defense Base Act.

I am George R. Fay, Executive Vice President of Worldwide Property and Casualty Claim for CNA Financial Corporation. Before joining CNA in July 2006, I was Executive Vice President & Chief Services Officer at The Chubb Corporation. I have more than 30 years of experience in the insurance industry.

I retired from the U.S. Army Reserve as Major General in May 2008, after 38 years of service including almost 4 years on active duty in support of the Global War on Terrorism and Operation Iraqi Freedom. During those 4 years, I served in many parts of the world, including Iraq and Afghanistan, side-by-side with defense contractors in every location. I graduated from St. Peter's College with a degree in Economics and from St. John's University with an MBA in Finance. It is based on this background that I believe I am well-equipped to testify today.

CNA understands that this hearing focuses on two categories of concern under the Defense Base Act: (1) allegations of profiteering; and (2) concerns regarding claims handling. CNA is pleased to be able to respond today and to have the opportunity to demonstrate that neither of these categories of concern applies to CNA.

This Subcommittee and its full Committee have focused on one part of this business as deeply troubled by charges of improperly inflated premiums amounting to war profiteering and other serious financial concerns. I will explain why CNA's role in this part of the business has been miniscule since 2006. The full Committee and the Subcommittee have also raised concerns of a pattern of routine, intentional, unjustified denials of claims by injured workers. If true, these would be tragic stories, but they are not CNA's story. The most

egregious statistics referenced by Chairman Waxman in the 2008 Subcommittee hearing related to this subject—95 percent losses in administrative hearings, 30-40 percent of claims ending up in administrative hearings—are not part of CNA's record. Like people, no company is perfect. CNA too can improve its performance and we will continue to strive to do so. But I will show how, overall, CNA is part of the solution, not the problems that concern this Subcommittee.

CNA shares the Subcommittee's view that civilian workers in Afghanistan, Iraq and elsewhere around the world are performing a crucial service for the military and this country and that they deserve fair treatment in the administration of insurance claims. I understand well the sacrifices being made by the men and women who support our military operations in Iraq and Afghanistan, and those who support them, and I am pleased to be part of the CNA family, which takes pride in supporting those who make such sacrifices.

I will begin today by providing some background about CNA, after which I will briefly describe the Defense Base Act, and the difference between at-large contracts (known as "non-program") and government competitively-bid request for proposal ("RFP") program contracts (known as "program"). As I will explain, CNA policies comprise only a small percentage of the so-called "at-large" contracts, which are those at the core of the Subcommittee's focus on financial

concerns today and were the subject of the Subcommittee's hearing last year. In contrast, CNA is currently the sole provider of the widely-praised "program" contracts. We believe that our chief contribution to this discussion is the opportunity to share our experience as the provider of choice in the program business, which can serve as a model for our peers who dominate the non-program business.

I will also address the Subcommittee's other category of concern by discussing CNA's claims-handling process, detailing our efforts to provide resources to civilian workers overseas, our commitment to each and every policy holder, and our attempts to review each claim thoughtfully, while operating within the strict standards required by law. The Subcommittee has concerns that there are intentional, systemic delays and denials in the overall DBA claims handling process. I can say with certainty that CNA is not engaging in these tactics; a preliminary review of a significant and representative number of our files clearly supports this conclusion. Finally, I will provide CNA's recommendations for improving the process governing DBA contracts—recommendations that will lead to more efficient and cost-effective claims-handling, a goal CNA shares with the Subcommittee.

Since 1897, CNA has built a tradition of anticipating and responding to the needs of our customers, distributors and business partners. From our early years of insuring railroad workers, we have honored our commitments with integrity and provided products that keep pace with our customers' ever-changing business risks, in the process making CNA one of the most trusted names in commercial insurance.

We are committed to providing superior customer service and building lasting relationships through our expert underwriting as well as risk control and claims services, which have been recognized by leading industry associations. In 2008, CNA received the Greenwich Associates Claims Management Quality Award for consistently high claims ratings among the majority of our clients. And, with our industry partners, we have developed safety equipment and risk control training programs that protect thousands of workers.

In addition, CNA takes its connection to the community seriously. We have a longstanding tradition of supporting local nonprofit organizations – from the USO to the American Red Cross – that work tirelessly to improve the quality of life in the communities where CNA does business and where our employees live, work and volunteer.

Headquartered in Chicago, CNA has approximately 9,000 employees in offices throughout the U.S., Canada, Argentina and Europe. We are the 7th largest U.S. commercial insurer and the 13th largest U.S. property and casualty insurer, providing insurance protection to more than one million businesses and professionals in the U.S. and internationally.

The Defense Base Act

As the members of the Subcommittee are well aware, the Defense Base Act (DBA) of 1941 is an extension of the Longshore and Harbor Workers' Compensation Act (Longshore Act). Under the DBA, contractors or subcontractors are required to purchase private insurance that provides medical care and disability payments to civilian workers for injuries sustained on the job, as well as death benefits to the families of employees who are killed on the job. Essentially, DBA is a federally-mandated broad form of Workers' Compensation provided to overseas civilian workers.

The cost of DBA insurance premiums is borne by the contracting agency. The insurer covers all workers' compensation-type claims, but claims made as a result of war-related injuries are reimbursed by the government under the War Hazards Compensation Act.

Different agencies handle the DBA requirements differently. The State Department, United States Agency for International Development (USAID) and the Army Corps of Engineers (which is overseen by the Department of Defense), accept bids from various insurance providers and, based on the bids, select one provider. Thus, these agencies conduct a competition to select insurance carriers using criteria including reasonable fixed rates and high-quality service. With these criteria in mind, these agencies have made CNA their provider of choice.

In contrast, the Department of Defense (DOD) (with the exception of the Army Corps of Engineers' pilot program), allows contractors to negotiate their own individual private insurance contracts to cover their employees, also known as "non-program" coverage, through an at-large system. This non-program policy results in coverage by many different private insurers. CNA provides only a very small and shrinking percentage of non-program coverage to the Department of Defense.

Thus, CNA has two markets for its Defense Base Act policies: at-large or "non-program" coverage and government competitively-bid "program" contracts. Neither at-large coverage nor program contracts comprises a significant portion of CNA's total business.

Government Agency Competitively-Bid Program Contracts

CNA is the *sole* provider of the program business for the State Department, USAID, and the Army Corps of Engineers, all of which accept competitive bids from insurance providers. This is widely believed to be the best way in which to award DBA insurance contracts. Indeed, in introducing the issue of DBA insurance in his 2008 hearing on the subject, Chairman Waxman lauded the manner in which these agencies went about choosing an insurer, stating that they had "approached this requirement responsibly." This approach creates competition among insurers to provide the best rates and services to the sponsoring agencies.

It is impressive, then, that after an open bidding process, these agencies have chosen to award us with these contracts again and again. This speaks not only to our fairness in setting rates—CNA is aware of no complaints on our pricing for these program contracts—but also our reputation for attention in claims handling and provision of services.

Indeed, in 2008, Chairman Waxman, in an illustration of how to operate under the DBA, stated that CNA actually *incurred 8 percent more* in claims and expenses than it received in premiums under those contracts. CNA estimates that we will pay out 8 percent eventually, but that this will not develop for a number of years. In fact, CNA has net underwriting losses of approximately $15 million under these contracts of the $180 million in premiums it received. This underwriting loss is in line with losses typically experienced by Workers' Compensation insurers. CNA continues to handle the program business, despite these losses, which in our eyes are significantly worse than the industry average over the same years.

Non-Program Coverage

As stated earlier, with the exception of the Army Corps of Engineers pilot program, DOD contractors are required to follow a different approach to choosing insurers for their civilian employees. In contrast to the other agencies, DOD contractors may select the policy for their contractors from an insurer of their choice. This at-large system, under which, comparatively speaking, CNA currently has very little premium, is at the center of the Subcommittee's focus today on questions of profiteering.

In contrast to the coverage CNA provides on DBA program policies, from 2002 to 2007, our premium accounted for only an average of about 7 percent of all DBA non-program premium. More recently, in both 2006 and 2007, CNA's non-program market share was much lower, only about 3 percent. In 2008, we estimate that AIG had about an 80 percent market share, ACE had about a 10 percent share, Chubb occupied about a 4-5 percent market share, and CNA had about a 3 percent market share. Currently, CNA has only about 270 non-program DBA policies.

Moreover, CNA's non-program DBA policies represent only a small fraction of our overall business. Non-program CNA DBA premiums account for only 1.7 percent of all of CNA's U.S. Workers' Compensation premiums (excluding residual markets), and only 0.2 percent of CNA's total premiums. Put another way, for every $500.00 of premium CNA wrote from 2002 to 2007, only about $1.00 was non-program premium. In sum, CNA is not a significant provider in this market—this market that is at the center of the Subcommittee's focus today.

No matter how small the market, CNA takes all of our responsibilities seriously, including underwriting. Although we occupy such a small share, I

believe that a short explanation of our non-program underwriting process will put some numbers into perspective.

In our underwriting, CNA generally has based non-program premiums on analogous rates for similar benefit levels for Longshoremen and Harborworkers coverage, adjusted as appropriate, for DBA market forces, exposure to loss and loss experience. Premiums paid to insurers cover losses arising from those policies, overhead for claims and underwriting expenses, and agent commissions and taxes. There is further netting of anticipated War Hazard Recoveries, which are payable directly to CNA from the federal government. Underwriting gain or loss is what is left after deducting these from total premiums.

Significantly, because CNA's at-large share and premium volume are low, this business can be highly volatile. Volatility in potential losses—particularly in the earliest years of an insurance program like this one with catastrophic injury potential—is usually reflected in higher initial rates. These initial rates will reduce over time, as the information we have becomes more stable and predictable with more mature program experience. This is particularly true for a Workers' Compensation policy that provides unlimited lifetime medical coverage for the covered injury. CNA has closely monitored our

results for the at-large program and in response to results, lowered its rates on the non-program business by about 10 percent from 2007 to 2008 and an additional 14 percent so far in 2009. CNA is committed to providing fair rates, and we continue to monitor our results and adjust rates accordingly as our experience grows.

CNA estimated our combined profits on program and non-program policies in response to Congressman Waxman's request last year. At that time, we estimated that we had only a 14.6 percent underwriting gain on all DBA programs for the years 2002 through 2007. The best estimate we have now for our underwriting gain for 2008 under the DBA program is 9 percent.

Of all of the DBA business written by CNA in 2008, non-program DBA business accounts for only 13 percent. Significantly, 87 percent of CNA's DBA business is in the sector that was lauded by Chairman Waxman.

Claims-Handling Process

I will once again make this very clear: we take very seriously any concerns relating to how we handle our claims. But before directly addressing – and refuting – any allegations that we might be intentionally and systematically delaying or denying claims, I believe it would be helpful to provide a brief

overview of what our claims personnel do and the challenges they face when handling DBA claims.

CNA has a dedicated team of experienced claims-handlers available around the clock to respond to DBA claims. We provide a centralized point of contact that is available 24 hours a day, seven days a week for all DBA claims. We take each claim seriously as a company, and I take each claim seriously as an Executive Vice President. I would respectfully request that the Chairman and the other members of the Subcommittee please inform me of any individual who has shared any concerns or complaints with the members or their staffs of which we have not already been made aware.

Importantly, especially where DBA claims are concerned, we handle claims in eight languages – English, Arabic, Farsi, Urdu, Hindi, Tagalog, French, and Spanish. We offer medical transport worldwide for medical evacuation and repatriation for more serious cases.

CNA is dedicated to the timely and vigorous investigation of DBA insurance claims, and its selection as the primary insurer by the Department of State, USAID and the Army Corps of Engineers speaks volumes about the high-quality service we have provided. Still, many challenges inherent to the DBA insurance system exist, and CNA and other insurance providers must operate

within a strict regulatory scheme created at a very different time for very different claims, a scheme that now has little applicability to today's changed realities.

Under the regulatory scheme, among other requirements, insurance providers have only 14 days to decide whether to provide compensation for or deny any claim or portion thereof. This 14-day requirement did not contemplate the realities and complications of today's world. The DBA was created in 1941 to help civilian workers during World War II, when the United States used civilian contractors only sparingly. By comparison, there were 200,000 civilian contractors working in Iraq and Afghanistan last year. To put this in perspective, that is more than the highest number of military personnel that have ever served at any one time in Iraq and Afghanistan.

Each year between 2003 and 2007, 11,000 civilian contractors filed injury claims under the Defense Base Act, twenty times the number of claims made in previous years. Total payments for health care and benefits related to these claims rose fourteenfold during the first four years of the Iraq war, to more than $170 million annually.

This significant increase in the volume of claims submitted in recent years, however, is only part of the story. While DBA claims appear on their face

to be nothing more than routine Workers' Compensation claims, in reality, they are far more complex. First, just the sheer logistics involved in processing these claims are daunting. There is a significant challenge in trying to communicate with claimants and gather information when both the people and the records are located halfway across the world. On top of this, of course, is that we are often performing these services in a theatre of war, with the attendant strain on systems, schedules and psyches.

The extremely tight timeframe of 14 days that has been imposed by the regulatory scheme, however, allows no room for these realities. According to the law, 14 days is a hard deadline that applies without regard to whether the claims representative needs to contact a physician from a neighboring state or one halfway around the world in a combat zone. The unfortunate result is that claims representatives are in effect obliged to file a notice with the Department of Labor that, while often intended as nothing more than a placeholder, is improperly interpreted by the Department as either an improper delay, or worse, as an outright denial.

Beyond war, geography and time differences, there is a fundamentally different incentive structure for civilian contractors in these combat theatres than for employees who file more traditional Workers' Compensation

claims. Civilian contractors earn double or triple what they can earn in their home countries, and our experience is that it is not uncommon for them to abandon claims that their employers filed on their behalf because even the maximum benefits available under DBA pale in comparison to their contractor wages. Often, however, their decisions not to not pursue claims are never communicated to the claims representative, who has continued in the meantime to spend time and energy in pursuit of information under the previously-described circumstances. This significantly different financial incentive, with its effect on claim abandonment, is distinctly different from the typical Workers' Compensation claims experience.

Finally, even when an injured worker pursues a claim and the claims representative is able to assist with gathering the required information, cultural and structural differences can present real roadblocks, for reasons such as different disclosure rules for treating medical providers in foreign countries or different or functionally non-existent banking systems, which are needed as a repository for benefit payments.

CNA understands why these challenges exist and we do everything we can, as a company, to overcome these difficult conditions to serve our customers effectively. Given the seriousness with which we approach these claims, it is

disturbing that we are here today facing accusations that carriers administering DBA programs routinely deny and delay payments to injured contractors. While I cannot comment on the practices of other carriers, I can unequivocally state that it is not CNA's practice to unfairly deny or delay any claim, let alone a DBA claim.

In order to give the Subcommittee a better sense as to how CNA goes about handling DBA claims, we conducted a preliminary analysis of 708 claims reported to CNA from June 1, 2008 to December 31, 2008. Our first order of business with any claim is to try to reach out to the claimant as fast as we can. I have set an internal goal to attempt to reach the claimant and insured within 24 hours of first notice to CNA. Obviously, as I previously mentioned, there are significant challenges in doing this with DBA claims because the claimants are often halfway way around the world in a war zone. Yet despite these challenges, I am pleased to state that our preliminary file review revealed that the CNA claim professionals make initial contact with the claimant within 24 hours of the claim 86 percent of the time.

Beyond simply making contact, our claims people must also attempt to gather key information to make important determinations within what I described earlier as the 14-day regulatory rule. Clearly, this is an unrealistically

short period of time given the logistics of addressing overseas claims. There have been suggestions that because of the time pressure created by these logistical problems, carriers just routinely deny claims. Again, while I cannot comment on the practices of other carriers, despite the challenges, CNA absolutely attempts in good faith to make a compensability decision within the 14-day period. Indeed, in the file sample we reviewed, we found we only denied claims at the 14-day deadline approximately 25 percent of the time. Stated differently, CNA was able to make a compensability decision – meaning a decision to accept the claim – within the 14-day deadline approximately 75 percent of the time.

The 25 percent denial figure, though, also overstates the percentage of claims that we determined were non-compensable. For the 25 percent where we denied, we found that about 37 percent of those claims were denied for insufficient information. Of those files in which we denied within the initial 14 days, we later picked up benefits on approximately 12 percent based on the receipt of additional information. The fact that we are obliged to report as denials those situations where we do not yet have sufficient information to evaluate the claim is the unintended result of the arbitrary and misleading requirements of the 14-day rule. This is especially true when one considers

that—even after being forced to file a notice of denial for insufficient information—our claims people continue to attempt to obtain supporting information.

Looking at the status of claims beyond the 14-day point bears this out as well. In our preliminary review of those claims in which compensability was challenged, only about 9 percent of the claims were actively challenged through litigation by the injured worker. These statistics are consistent with my experience—we do what we can to quickly make claim decisions, we settle disputes when we can, and we only dispute a small portion of the claims, and only when absolutely necessary. In addition, we examined a claims file sample of about 200 closed claims from 2002 to 2005, with consistent results.

There also have been accusations that injured claimants are forced to pursue their claims through protracted litigation, and when they do, they prevail over 95 percent of the time before administrative hearings. Again, I cannot comment on the practices of other carriers, however this is wholly inconsistent with CNA's experience. First, it is not CNA's goal to engage in protracted litigation. Indeed, with the 5500 or so claims filed with us in the past seven years, we believe that we have only gone to an administrative ruling in fewer than 20 cases. Our goal is to try to settle disputes when we can. In those rare

instances where that has not been possible, however, our experience has been that more often than not the administrative law judge—a neutral, third party—has validated our non-compensability determination in whole or in part. In short, our goal is not to litigate cases, but when we must, we have a good faith basis for doing so.

At least with regard to CNA, all of these concerns that have been raised are merely one side of the story – and, to our knowledge, there are very few such stories. Media reports neglect to tell the lengths to which CNA claim specialists endeavor to ensure that a claimant receives timely and appropriate medical and financial benefits. Federal and state statutes, as well as CNA's own corporate policy, prohibit me from commenting on individual claimants without their consent. However, to accuse our claim specialists – who view the injured workers who file claims as patriotic partners of our men and women in uniform – of intentionally delaying or denying claims is to deprive them of the meaning and value they derive from their tireless efforts to provide a comprehensive range of covered services, including arranging for medevacs and other urgent care, or long-term hospital, recuperative and care services, and insuring that claimants receive financial benefits owed.

Recommendations:

From our experience, these concerns clearly demonstrate the unfortunate but real effects of a flawed statutory and regulatory scheme. For that reason, CNA will be pleased to assist this Subcommittee in its efforts to consider changes and improvements to the DBA program. We share the Subcommittee's concern that insurers not use the DBA system to inflate premiums and agree that the claims-handling process could be improved by adjustments to the DBA's archaic regulatory requirements.

Recommendations:

Change Unrealistic Claims-Handling and Compensation Requirements.

Our recommendations include, first, refining and in some instances extending, the 14-day rule to allow for a more detailed analysis and review of claims. It is important to CNA to be able to process all claims fairly, which, as I have detailed, is especially difficult in the case of DBA claims when they are received from remote areas in war zones where communications are difficult. Unfortunately, the result is that insurance carriers are often forced to file LS-207 forms initially denying a portion of the claim or the entire claim to avoid penalties or simply to buy more time, a necessary action that is often—and

understandably—misinterpreted. A regulatory scheme that creates such incentives can only produce unintended, and sometimes, tragic results.

The Department of Labor requires that payments be made to claimants within 10 days, even if these payments are being made to individuals overseas. This requirement is extremely difficult to satisfy because payments to DBA claimants are typically sent using wire transfers. This 10-day time requirement should also be adjusted to reflect the realities of the current day.

Finally, we further recommend an increase on the limit for funeral benefits. Under the Act, it is $3,000, which does not reflect current funeral costs.

Adopt a Competitively-Bid Program Method of Awarding Contracts.

Second, CNA believes that DOD should adopt a modified request for proposal-awarded program method, like the one used by the State Department, USAID, and the Army Corps of Engineers, to cover all of their civilian contractors. An RFP-awarded program could be established for each of the divisions of the military within DOD. If the Army, Navy, Air Force, Marines, Merchant Marine and other affiliated, but independent, branches were to each have their own DBA programs, the insurance market might respond favorably to the respective requests for proposals. Each division could possibly also further subdivide into smaller groups to create their own competitively-bid programs as

well. The objective would be to have small enough groups to be relatively homogeneous and supportable by a single insurer, yet large enough to diversify the volatility of the risks. These fixed rate programs would also simplify the bidding (RFP) process for the contractors.

By some estimates, doing so could save the DOD $362 million. According to the GAO, in 2005, the State Department and USAID paid approximately $2 to $5 for every $100 of salary cost for DBA insurance, which was written by CNA, while the Defense Department contractors were paying DBA insurance rates between $10 and $21 per $100 of salary costs. GAO, Congress, and the Army's own auditors have recommended that the Defense Department implement an agency-wide single insurer risk-pool program for DBA insurance every year since 2005.

Conclusion

CNA's mission is to provide superior service to all of our customers, and we have been doing so for more than 100 years. We are a customer-focused company and we measure our success, in part, by our ability to deliver high-value products and high-quality service. In keeping with our mission, CNA shares the Subcommittee's view that civilian workers in Afghanistan and Iraq deserve fair treatment in the administration of insurance claims. Therefore, Mr.

Chairman, I thank you for the opportunity to discuss these issues today. I will be pleased to answer any questions you may have.

Mr. KUCINICH. I thank the gentleman. Mr. Moor, you may proceed. Please bring that mic close so every member of the committee can hear your testimony. Thank you.

STATEMENT OF KRISTIAN P. MOOR

Mr. MOOR. Mr. Chairman, Ranking Member Jordan, and members of the subcommittee, thank you for the invitation to appear before you today. AIG is pleased to participate in this hearing examining Defense Base Act [DBA], insurance for Federal contractors working overseas. Given the importance of this issue, AIG looks forward to working with the subcommittee on ways to improve the DBA program to ensure proper coverage for contractors.

The DBA program is one of the many lines of coverage offered by AIG's General Insurance. In order to provide the subcommittee with a better understanding of AIG's participation in the DBA program, I am joined today by Charles Schader, President of AIG's Worldwide Claims. Mr. Schader has 25 years of experience in insurance claims management, including extensive experience with the DBA program. He has provided testimony for the record that outlines AIG's participation in the program and identifies several areas where we think the program can be improved.

AIG has had a long and proud history of providing DBA coverage. While other insurers participate in the DBA program, no other insurer has created a center of excellence for the care of injured workers comparable to ours. AIG has also made significant investments in our claims management process to facilitate our participation in the DBA program.

AIG now has claims professionals located in six global offices that are equipped to handle unique regional and local needs. As but one example, the Dubai office staff is fluent in four languages. It has developed expertise in overcoming geographic and cultural obstacles, paying benefits in country in local currencies, and conducting investigations in the Middle East to locate claimants while obtaining witness statements and verifying dependency.

As Mr. Schader has identified in his written statement, AIG believes that there are three key areas where the DBA program can be improved through a combination of legislative and regulatory reform. The first would be providing detailed, accurate status reports to claimants instead of the LS 207 Contraversion Notice. The second would be rationalizing and simplifying the calculation of average weekly wage. The third and final area would be interagency cooperation on the diagnosis, prognosis, and treatment of Post-Traumatic Stress Disorder.

Thank you again for the opportunity to participate in today's hearing. We look forward to answering any questions the subcommittee may have. In particular, Mr. Schader will be able to speak in greater detail regarding the DBA practices.

[The prepared statement of Mr. Moor follows:]

TESTIMONY OF MR. KRISTIAN P. MOOR,
AIG EXECUTIVE VICE PRESIDENT AND
PRESIDENT OF AIU HOLDINGS, INC.

DOMESTIC POLICY SUBCOMMITTEE
OVERSIGHT AND GOVERNMENT REFORM COMMITTEE
THURSDAY, JUNE 18, 2009
2154 RAYBURN
2:00 PM

CHAIRMAN KUCINICH, RANKING MEMBER JORDAN, SENATOR SANDERS, AND MEMBERS OF THE SUBCOMMITTEE, THANK YOU FOR THE INVITATION TO APPEAR BEFORE YOU TODAY.

AIG IS PLEASED TO PARTICIPATE IN THIS HEARING EXAMINING DEFENSE BASE ACT (DBA) INSURANCE FOR FEDERAL CONTRACTORS WORKING OVERSEAS. GIVEN THE IMPORTANCE OF THIS ISSUE, AIG LOOKS FORWARD TO WORKING WITH THE SUBCOMMITTEE ON WAYS TO IMPROVE THE DBA PROGRAM TO ENSURE PROPER COVERAGE FOR CONTRACTORS. THE DBA PROGRAM IS ONE OF MANY LINES OF COVERAGE OFFERED BY AIG GENERAL INSURANCE.

IN ORDER TO PROVIDE THE SUBCOMMITTEE A BETTER UNDERSTANDING OF AIG'S PARTICIPATION IN THE DBA PROGRAM, I AM JOINED TODAY BY CHARLES SCHADER, PRESIDENT OF AIG WORLDWIDE CLAIMS.

MR. SCHADER HAS 25 YEARS OF EXPERIENCE IN INSURANCE CLAIMS MANAGEMENT, INCLUDING EXTENSIVE EXPERIENCE WITH THE DBA PROGRAM. HE HAS PROVIDED TESTIMONY FOR THE RECORD THAT OUTLINES AIG'S PARTICIPATION IN THE PROGRAM AND IDENTIFIES SEVERAL AREAS WHERE WE THINK THE PROGRAM CAN BE IMPROVED.

AIG HAS A LONG AND PROUD HISTORY OF PROVIDING DBA COVERAGE. WHILE OTHER INSURERS PARTICIPATE IN THE DBA PROGRAM, NO OTHER INSURER HAS CREATED A CENTER OF EXCELLENCE FOR THE CARE OF INJURED WORKERS COMPARABLE TO OURS.

AIG HAS ALSO MADE SIGNIFICANT INVESTMENTS IN OUR CLAIMS MANAGEMENT PROCESS TO FACILITATE OUR PARTICIPATION IN THE DBA PROGRAM. AIG NOW HAS CLAIMS PROFESSIONALS LOCATED IN SIX GLOBAL OFFICES THAT ARE EQUIPPED TO HANDLE UNIQUE REGIONAL AND LOCAL NEEDS.

AS BUT ONE EXAMPLE, THE DUBAI OFFICE STAFF IS FLUENT IN FOUR LANGUAGES. IT HAS DEVELOPED EXPERTISE IN OVERCOMING GEOGRAPHIC AND CULTURAL OBSTACLES, PAYING BENEFITS IN-COUNTRY IN LOCAL CURRENCIES, AND CONDUCTING INVESTIGATIONS IN THE MIDDLE EAST TO LOCATE CLAIMANTS, WHILE OBTAINING WITNESS STATEMENTS AND VERIFYING DEPENDENCY.

AS MR. SCHADER HAS IDENTIFIED IN HIS WRITTEN STATEMENT, AIG BELIEVES THAT THERE ARE THREE KEY AREAS WHERE THE DBA PROGRAM CAN BE IMPROVED THROUGH A COMBINATION OF LEGISLATIVE AND REGULATORY REFORM:

1) PROVIDING DETAILED, ACCURATE STATUS REPORTS TO CLAIMANTS INSTEAD OF THE LS-207 CONTROVERTION NOTICE;

2) RATIONALIZING AND SIMPLIFYING THE CALCULATION OF "AVERAGE WEEKLY WAGE"; AND

3) INTERAGENCY COOPERATION ON THE DIAGNOSIS, PROGNOSIS AND TREATMENT OF POST TRAUAMATIC STRESS DISORDER.

THANK YOU AGAIN FOR THE OPPORTUNITY TO PARTICIPATE IN TODAY'S HEARING. WE LOOK FORWARD TO ANSWERING ANY QUESTIONS THE SUBCOMMITTEE MAY HAVE. IN PARTICULAR, MR. SCHADER WILL BE ABLE TO SPEAK IN GREATER DETAIL REGARDING OUR DBA PRACTICES.

[The prepared statement of Mr. Schader follows:]

TESTIMONY BY MR. CHARLES R. SCHADER,
PRESIDENT OF WORLDWIDE CLAIMS
AMERICAN INTERNATIONAL GROUP

BEFORE THE U. S. HOUSE OF REPRESENTATIVES DOMESTIC POLICY SUBCOMMITTEE
OF THE OVERSIGHT AND GOVERNMENT REFORM COMMITTEE
THURSDAY, JUNE 18, 2009

MR. CHAIRMAN, RANKING MEMBER JORDAN, SENATOR SANDERS, AND MEMBERS OF THE SUBCOMMITTEE, THANK YOU FOR THE INVITATION TO APPEAR BEFORE YOU TODAY.

AS PRESIDENT OF AIG'S WORLDWIDE CLAIMS OPERATIONS, I HAVE 25 YEARS OF EXPERIENCE IN INSURANCE CLAIMS MANAGEMENT, INCLUDING EXTENSIVE EXPERIENCE WITH THE DEFENSE BASE ACT PROGRAM. I AM HAPPY TO SPEAK TO YOU ABOUT ITS STRENGTHS AND CHALLENGES.

AIG IS PROUD TO PROVIDE DEFENSE BASE ACT AND WAR HAZARDS COMPENSATION ACT COVERAGE TO AMERICANS AND NON-U.S. NATIONALS WORKING ABROAD IN SUPPORT OF THE UNITED STATES GOVERNMENT. FOR NEARLY A HALF CENTURY, AIG HAS PROVIDED VALUABLE COVERAGE AND SERVICES AROUND THE WORLD, FROM RECONSTRUCTION IN JAPAN, GERMANY AND BOSNIA IN PRIOR YEARS, TO

AFGHANISTAN AND IRAQ TODAY. ALL TOLD, AIG HAS PROVIDED DEFENSE BASE ACT (DBA) COVERAGE IN MORE THAN NINETY COUNTRIES AROUND THE GLOBE.

WITH THE ADVENT OF HOSTILITIES IN AFGHANISTAN AND IRAQ AND THE INCREASED EMPLOYMENT OF PRIVATE CONTRACTORS BY THE U.S. MILITARY, AIG'S DBA BUSINESS HAS GROWN EXPONENTIALLY. AIG HAS HANDLED 36,000 CLAIMS SINCE 2002, FOUR TIMES THE NUMBER PROCESSED IN THE ENTIRE PRIOR PERIOD SINCE WE FIRST BEGAN WRITING AND SERVICING THIS BUSINESS.

WITH DECADES OF UNSURPASSED SERVICE UNDER ITS BELT, AIG HAS CREATED A CENTER OF EXCELLENCE FOR THE CARE OF INJURED WORKERS THAT IS UNMATCHED BY ANY OF OUR COMPETITORS. SINCE 2005, OUR AIG TRAVEL ASSIST DIVISION HAS UNDERTAKEN 2,000 MEDICAL EVACUATIONS OF SEVERELY INJURED WORKERS, USING BOTH COMMERCIAL AIRLINES AND AIR AMBULANCES, IN CIRCUMSTANCES WHERE TIMELY, SKILLED MEDICAL TREATMENT HAS BEEN CRITICAL TO THEIR RECOVERY. EVACUATED WORKERS HAVE EXTENSIVE INJURIES RANGING FROM SEVERE BURNS, DISMEMBERMENTS, HEAD TRAUMA AND CATASTROPHIC WOUNDS TO HEART ATTACKS AND OTHER ILLNESSES AGGRAVATED BY THE STRESS OF WORKING UNDER WAR ZONE CONDITIONS.

THE TRAVEL ASSIST TEAM INCLUDES EIGHT BOARD-CERTIFIED PHYSICIANS, TWENTY-NINE MULTILINGUAL MEDICAL ASSISTANCE COORDINATORS, FOURTEEN NURSES AND PARAMEDICS LOCATED IN STRATEGIC HUBS ACROSS THE GLOBE.

TO SUPPORT THOSE INJURED IN IRAQ AND AFGHANISTAN, TRAVEL ASSIST HAS DEVELOPED RELATIONSHIPS WITH COMMERCIAL AIRLINES, AIR AMBULANCE SERVICES, AND SPECIAL CARE MEDICAL FACILITIES IN THE REGION --- IN ADDITION TO THE USE OF MILITARY TRANSPORT AND NUMEROUS MEDICAL CENTERS THROUGHOUT THE WORLD.

AFTER EVACUATION, TRAVEL ASSIST STAYS IN CONTACT WITH INJURED WORKERS AND CONTINUES TO MONITOR THEIR MEDICAL CONDITION. TRAVEL ASSIST ALSO PROVIDES SERVICES SUCH AS REPATRIATION OF REMAINS, SHIPMENT OF MEDICAL RECORDS AND PRESCRIPTION MEDICATION, AND MEDICAL AND LEGAL REFERRALS.

AIG CURRENTLY INSURES MORE THAN 1,500 CONTRACTORS OPERATING IN MORE THAN NINETY COUNTRIES. OVER THE PAST SEVEN YEARS, AS THE NUMBER OF CLAIMS HAS SO RAPIDLY ESCALATED, OUR CLAIMS STAFF HAS LIKEWISE INCREASED FROM FIVE DBA CLAIMS PROFESSIONALS TO SEVENTY, LOCATED IN SIX GLOBAL OFFICES --- DALLAS, NEW YORK, DUBAI, ISTANBUL, SAN JUAN, AND MANCHESTER (UK).

EACH OFFICE IS EQUIPPED TO HANDLE UNIQUE REGIONAL AND LOCAL NEEDS. FOR EXAMPLE, THE DUBAI OFFICE STAFF IS FLUENT IN ARABIC, ENGLISH, FRENCH AND TAGALONG AND HAS DEVELOPED EXPERTISE IN OVERCOMING GEOGRAPHIC AND CULTURAL OBSTACLES, PAYING BENEFITS IN-COUNTRY IN LOCAL CURRENCIES, AND CONDUCTING INVESTIGATIONS IN THE MIDDLE EAST TO LOCATE CLAIMANTS, OBTAIN WITNESS STATEMENTS AND VERIFY DEPENDENCY.

AIG HAS LEARNED THROUGH EXPERIENCE, THAT FAMILIARITY WITH LOCAL CUSTOMS IS ESSENTIAL TO SUCCESSFULLY ADDRESS MANY DBA CLAIMS. IN AFGHANISTAN, PAYING BENEFITS CAN BE DIFFICULT DUE TO SPARSE GOVERNMENT RECORDS, A LARGE DISPLACED POPULATION AND THE DICTATES OF LOCAL CULTURE. AFGHAN CUSTOM DOES NOT PERMIT THE WIDOW OF A DECEASED DBA CLAIMANT TO DIRECTLY RECEIVE DEATH BENEFITS. IN THESE SITUATIONS, AIG ARRANGES FOR A FEMALE AFGHAN PHYSICIAN WHO ACTS AS AN INTERMEDIARY. SHE OBTAINS A POWER OF ATTORNEY FROM THE WIDOW ALLOWING A MALE RELATIVE TO RECEIVE THE BENEFITS IN HIS BANK ACCOUNT. THE MALE RELATIVE THEN DISTRIBUTES THE BENEFITS BACK TO THE WIDOW. IN MOST CASES, THIS IS THE ***ONLY*** WAY BENEFITS CAN BE DISTRIBUTED TO AFGHAN WIDOWS.

AIG ALSO RECEIVES CLAIMS LOCALLY, STATESIDE, OR ON-LINE THROUGH AN INTERNET- BASED REPORTING SYSTEM. CLAIMS MAY CURRENTLY BE REPORTED IN ENGLISH, TURKISH, OR ARABIC, AND SOON MAY BE REPORTED IN PASHTUN AND TAJIK TO FURTHER ASSIST CONTRACTORS AND CLAIMANTS IN AFGHANISTAN. AIG ALSO PROVIDES CLAIM FORMS IN NUMEROUS LANGUAGES AND WAS THE FIRST INSURER TO TRANSLATE DBA FORMS INTO TURKISH AND ARABIC.

WHILE AIG IS PROUD OF ITS RECORD PROVIDING DBA COVERAGE, WE BELIEVE THERE ARE THREE KEY AREAS WHERE THE PROGRAM CAN BE IMPROVED THROUGH A COMBINATION OF LEGISLATIVE AND REGULATORY REFORM:

1) PROVIDING DETAILED, ACCURATE STATUS REPORTS TO CLAIMANTS INSTEAD OF THE LS-207 CONTROVERTION NOTICE;

2) RATIONALIZING AND SIMPLIFYING THE CALCULATION OF "AVERAGE WEEKLY WAGE"; AND

3) INTERAGENCY COOPERATION ON THE DIAGNOSIS, PROGNOSIS AND TREATMENT OF POST TRAUAMATIC STRESS DISORDER (PTSD).

ACCURATE STATUS REPORTS

FIRST, AS YOU KNOW, BY STATUTE, A DBA INSURER MUST MAKE THE FIRST CLAIM PAYMENT WITHIN FOURTEEN DAYS OF NOTICE OF CLAIM. THIS TYPE OF REQUIREMENT IS FOUND IN MANY DOMESTIC STATE WORKERS' COMPENSATION ACTS AS WELL. IN 1941 THE DBA WAS CREATED AS AN ADD-ON TO THE LONGSHORE & HARBOR WORKERS COMPENSATION ACT, A FEDERAL ENACTMENT ITSELF BASED ON STATE WORKERS' COMPENSATION CONCEPTS.

THERE ARE, HOWEVER, INHERENT DIFFERENCES THAT DISTINGUISH THE HANDLING OF DBA CLAIMS FROM DOMESTIC STATE WORKERS' COMPENSATION CLAIMS – AND THOSE DIFFERENCES CREATE OBSTACLES THAT FRUSTRATE RAPID CLAIM RESOLUTION. FOR STATE WORKERS' COMPENSATION CLAIMS, WORKERS ARE GENERALLY LOCATED WITHIN THE UNITED STATES AND ARE ABLE TO OBTAIN PROMPT MEDICAL CARE, NOTIFY THEIR EMPLOYERS PROMPTLY, AND ENSURE THAT MEDICAL DOCUMENTATION AND DETAILS OF ACCIDENTS ARE PROMPTLY CONVEYED TO INSURERS AND EMPLOYERS.

MANY TREATING PHYSICIANS IN THE U.S. ARE FAMILIAR WITH WORKERS' COMPENSATION CLAIM REQUIREMENTS AND OFTEN ASSIST INJURED WORKERS IN COMPLETING THE PROCESS. IT IS COMMON FOR EXAMINERS TO MAKE CLAIM DETERMINATIONS WITHIN A SHORT PRESCRIBED TIME FRAME, SUCH AS FOURTEEN DAYS.

IN CONTRAST, DBA CLAIMS OFTEN INVOLVE WORKERS INJURED THOUSANDS OF MILES AWAY FROM HOME, IN A SHIFTING WAR ZONE WHERE BOTH MEDICAL TREATMENT AND DOCUMENTATION CAN BE DIFFICULT TO OBTAIN. EVEN DETERMINING THE FACTS OF AN ACCIDENT – THE LOCATION AND THE CIRCUMSTANCES – CAN BE A CHALLENGE. AND MANY CLAIMANTS ARE FOREIGN NATIONALS, PRESENTING NOT ONLY GEOGRAPHIC, BUT LANGUAGE AND CULTURAL OBSTACLES AS WELL. WITHOUT SUFFICIENT INFORMATION, EXAMINERS CANNOT MAKE TIMELY FINAL DETERMINATIONS WITHIN FOURTEEN DAYS.

THE INABILITY TO GATHER SUFFICIENT INFORMATION WITHIN FOURTEEN DAYS TO MAKE EITHER A COMPENSABILITY DETERMINATION OR MEDICAL EVALUATION DOES NOT TERMINATE THE CLAIMS ADJUDICATION PROCESS. OUR EXAMINERS CONTINUE THEIR INFORMATION GATHERING UNTIL THEY HAVE THE NECESSARY INFORMATION TO DRAW INFORMED, FINAL CONCLUSIONS.

IN COMPARABLE CIRCUMSTANCES, A STATE WORKERS' COMPENSATION CLAIMANT WOULD BE PROVIDED WITH A FORM OUTLINING THE STATUS OF THE CLAIM AND, IN MANY CASES, DESCRIBING WHAT FURTHER INFORMATION IS REQUIRED. HOWEVER, UNDER THE SAME SET OF FACTS, THE DEPARTMENT OF LABOR REQUIRES DBA INSURERS TO FILE A PRESCRIBED FORM LS-207 WHICH "CONTROVERTS" OR "DENIES"

A CLAIM EVEN THOUGH THERE HAS BEEN NO ACTUAL DENIAL OF THE CLAIM AT ALL. ON THE CONTRARY, INFORMATION GATHERING IS STILL ONGOING. TO CHARACTERIZE ALL SUCH CLAIMS AS "DENIED' IS NOT ONLY MISLEADING, IT IS PATENTLY INCORRECT.

FOR WORKERS SEEKING COMPENSATION BENEFITS AFTER THE HARROWING EXPERIENCE OF BEING INJURED IN A WAR ZONE, IN AN UNFAMILIAR LAND DISTANT FROM HOME, THE RECEIPT OF A "CONTROVERSION" NOTICE SPARKS UPSET, ANGER AND FRUSTRATION. WITH SIMPLE LEGISLATIVE AND REGULATORY CHANGE, THIS UNACCEPTABLE SCENARIO CAN BE EASILY AVOIDED.

IN AUGUST, 2006, IN COLLABORATION WITH THE DOL'S LOCAL NEW YORK OFFICE, AIG ADOPTED A PRACTICE THEN CURRENTLY USED IN NEW YORK STATE. INJURED WORKERS WHOSE CLAIMS WERE CLEARLY COMPENSABLE, BUT DID NOT HAVE SUFFICIENT MEDICAL OR WAGE INFORMATION IN THE FILE TO PERFORM A BENEFIT CALCULATION, RECEIVED A FORM ACCURATELY DESCRIBING THE OPEN AND ONGOING STATUS OF THE CLAIM.

HOWEVER, IN MARCH, 2008, THE DISTRICT DIRECTOR OF THE DOL'S NORFOLK, VIRGINIA OFFICE REJECTED THE USE OF THE NEW FORM SINCE IT DID NOT "CONTROVERT" THE CLAIM. THE

DISTRICT DIRECTOR THEN ADDITIONALLY FINED AIG FOR USING THE NEW FORM INSTEAD OF THE LS-207.

WE URGE A REVISION OF THE DOL'S MANDATORY REQUIREMENT OF THE LS-207 FORM. WE ENCOURAGE THE ADOPTION OF PROCESSES AND FORMS, AS ARE USED IN SO MANY STATES TODAY, WHICH PROVIDE CLAIMANTS WITH A MORE INFORMED, ACCURATE AND TRANSPARENT STATUS AS CLAIMS PROGRESS THROUGH THE EXAMINING PROCESS.

CALCULATION OF "AVERAGE WEEKLY WAGE"

ANOTHER AREA THAT DEMANDS ATTENTION ARE THE STATUTORY PROVISIONS PRESCRIBING THE CALCULATION OF THE "AVERAGE WEEKLY WAGE". IN OUR EXPERIENCE, THIS ISSUE CAUSES THE GREATEST NUMBER OF DISPUTES AND SUBSEQUENT APPEALS SINCE THIS CALCULATION CONSTITUTES THE BASIS FOR DETERMINING DISABILITY BENEFITS.

SECTION 910 WAS DRAFTED FOR LONGSHORE AND HARBOR WORKERS WHO PURSUE THEIR CAREERS IN A STABLE ENVIRONMENT WITH A PREDICTABLE CAREER PROGRESSION. IT WAS NOT DRAFTED FOR THOSE THOUSANDS OF EMPLOYEES WHO LEAVE STATESIDE EMPLOYMENT BEHIND AND HEAD INTO HAZARDOUS WAR ZONES FOR GREATLY ENHANCED SALARIES,

WITH THE INTENTION OF STAYING OVERSEAS FOR ONLY A YEAR OR TWO BEFORE RETURNING HOME.

SECTION 910 PROVIDES THREE METHODS OF CALCULATION. WHEN AND HOW EACH METHOD SHOULD APPLY, WHETHER A PARTICULAR METHOD IS MANDATORY IN SOME CIRCUMSTANCES AND DISCRETIONARY IN OTHERS, WHAT CONSTITUTES "SUBSTANTIALLY THE WHOLE" YEAR, ARE ONLY A FEW OF THE ISSUES FOR WHICH THERE ARE NO DEFINITIVE ANSWERS.

THERE IS LITTLE CONSISTENCY IN HOW DIFFERENT ADMINISTRATIVE LAW JUDGES APPLY THE METHODOLOGIES DELINEATED IN SECTION 910. THIS INCONSISTENCY LEADS TO AN INCREASED NUMBER OF APPEALS BY CLAIMANTS HOPING TO DRAW A MORE FAVORABLE DECISION THAN THE ORIGINAL CLAIMS DETERMINATION. IT OVERTAXES THE CADRE OF ADMINISTRATIVE LAW JUDGES WHO HEAR THESE CASES AND PROLONGS THE TIME FRAME FOR CLAIMANTS TO RECEIVE FINAL AWARDS. INCONSISTENCY HAS CONVERTED WHAT SHOULD BE AN EFFICIENT COMPENSATION SYSTEM INTO AN UNPREDICTABLE, PROLONGED LOTTERY. CLEARER, MORE PREDICTABLE RULES FOR CALCULATING THE "AVERAGE WEEKLY WAGE" WOULD LESSEN THE NUMBER OF DISPUTES AND ASSOCIATED FRICTIONAL COSTS, AND WOULD INCREASE THE SATISFACTION LEVEL OF CLAIMANTS, INSURERS AND

EMPLOYERS ALIKE. THIS AREA CRIES OUT FOR LEGISLATIVE REFORM.

INTERAGENCY COOPERATION ON PTSD

FINALLY, OF THE MANY THOUSANDS OF DBA CLAIMS AIG HANDLES, PTSD CLAIMS NUMBER ONLY A FEW HUNDRED. YET THE DIAGNOSIS, PROGNOSIS AND MANAGEMENT OF PTSD CLAIMS PRESENT SOME OF OUR MOST COMPLEX CHALLENGES.

THE U. S. DEPARTMENT OF VETERAN AFFAIRS HAS THE LARGEST CADRE OF SPECIALISTS SCHOOLED AND EXPERIENCED IN DIAGNOSING AND TREATING PTSD. WE BELIEVE THAT SUPPLEMENTING AIG'S EXPERTS WITH THE VA'S PANEL WOULD FURTHER ENHANCE THE CLAIMS ADJUDICATION PROCESS. IN THE PAST AIG HAS REQUESTED THE DOL TO REACH OUT AND ENGAGE ITS SISTER AGENCY IN A COOPERATIVE EFFORT. TO OUR KNOWLEDGE, THAT INTER-AGENCY COOPERATION HAS NEVER OCCURRED.

THANK YOU AGAIN FOR THE OPPORTUNITY TO SPEAK BEFORE YOU TODAY TO PROVIDE AIG'S RECOMMENDATIONS ON HOW THE DBA PROGRAM CAN BE IMPROVED. BASED ON AIG'S EXTENSIVE EXPERIENCE IN DBA AND WORKERS COMPENSATION ISSUES, THE SIMPLE REFORMS I HAVE BROADLY OUTLINED TODAY WOULD GO A LONG WAY TOWARD

IMPROVING THE MAJOR DEFICIENCIES IN TODAY'S DBA SYSTEM.

AIG PLEDGES TO CONTINUE WORKING WITH CHAIRMAN KUCINICH, RANKING MEMBER JORDAN, SENATOR SANDERS, AND THE SUBCOMMITTEE IN EVERY WAY POSSIBLE TO ACHIEVE THESE REFORMS. WE ARE SURE YOU ALL AGREE THAT THOSE ENGAGED IN SUPPORTING OUR MILITARY OVERSEAS DESERVE NO LESS.

Mr. KUCINICH. I thank the gentleman for his testimony.

General Fay, I was interested in your testimony. There seems to be a variance, according to staff, from your prepared testimony to what you presented to this committee in that you quoted from an internal committee document that hadn't been released. That was really the property of this committee. I just wondered where did you get your information from?

General FAY. I was given that by a member of our staff, sir, but I don't know where exactly they——

Mr. KUCINICH. What was the name of the member of your staff that gave that to you? You remember you are under oath. Who gave it to you?

General FAY. Yes. I got it from our Head of Legislative Affairs.

Mr. KUCINICH. Is your Head of Legislative Affairs here right now?

General FAY. Yes, she is.

Mr. KUCINICH. Who is that? Would they identify themselves? Would you like to come to the committee table? Do you want to identify yourself?

Ms. DAVIS. My name is Heather Davis.

Mr. KUCINICH. Would you like to be sworn? Do you have an attorney here?

Ms. DAVIS. No. I mean, we have several attorneys on staff. I am not an attorney.

Mr. KUCINICH. OK. Would you raise your right hand?

[Witness sworn.]

Mr. KUCINICH. I was referencing an internal document that had not been released that was quoted by General Fay. He said that you gave him that information. Is that correct?

Ms. DAVIS. To be completely honest, I was working with our parent company lobbyist, Loews Corp., Mr. Watson. It was either he or I that gave it to him.

Mr. KUCINICH. Where did the document come from? Mr. Fay said he got it from you. Where did you get it from?

Ms. DAVIS. I want to make sure I am clear. We were doing a lot of visits on the Hill. Steve, do you recall where it came from?

Mr. WATSON. It came from a committee staff member.

Mr. KUCINICH. Committee staff? Which committee staff, the Democratic committee staff?

Mr. WATSON. I don't believe so.

Mr. KUCINICH. This is tangential to the purpose of this hearing. But you are going to be subject to further questions from our attorneys where that document came from. It is really somewhat unprecedented for information that has not been released to the public to be in the hands of a witness who then uses it to criticize a committee report. This is something that we are going to find out, who gave you that. Then we will deal with that as an internal committee matter.

Yes, Mr. Jordan.

Mr. JORDAN. Mr. Chairman, I have just checked with the staff that is present here. They indicated that they did not give that document out. I certainly didn't and don't know of anyone on our staff that did.

This is highly unusual, too, that we are bringing in people from the audience who haven't been cleared and who we didn't know were going to be witnesses.

Mr. KUCINICH. No, I didn't expect that General Fay would be giving testimony that would reference an internal report, and then say that he himself did not know where that came from and refer to someone else. That is why we did it.

Now, we are not going to change the subject of this questioning. But I just want you to know, General Fay, and I want the gentlelady to know and the people in the audience who are involved, that you are going to be subject to further questioning about this. Thank you very much. You are dismissed.

[The information referred to follows:]

From: "Blankenburg, Dan" [Dan.Blankenburg@mail.house.gov]
Sent: 06/16/2009 02:37 PM AST
To: <heather.davis@cna.com>; Steve Watson
Subject: FW: DP Hearing Thursday, June 18, 2009 @2:00 pm., 2154 Rayburn HOB


061609 111th DP
Memo 061809.pdf

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From: Fromm, Adam
Sent: Tuesday, June 16, 2009 2:11 PM
To: Callen, Ashley; Blankenburg, Dan; Safavian, Jennifer
Subject: Fw: DP Hearing Thursday, June 18, 2009 @2:00 pm., 2154 Rayburn HOB
Importance: High

From: Gosa, Jean
To: Ahrens, Andrea; Almanza, Margie; Amstutz, Kari; Boyl, Molly; Brady, Larry; Cuaderes, John; Dwyer, Ryan; Edmond, Micah; Evans, Melissa; Fauls, Brian; Feyerherm, Alan; Fromm, Adam; Goodman, Wesley; Heaton, Joseph; Hixon, Christopher; Howard, Adam; Mattox, Pamela; Menorca, Diane; Neuder, Lisa; Okeeffe, Mary; Perdue, Lindsay; Poulios, George; Pritschau, Mary; Roman, Mark; Rother, Katy; Shearer, Steven; Smith, Aaron; Walker, Mark
Cc: Coleman, Claire; Bourke, Jaron
Sent: Tue Jun 16 14:09:52 2009
Subject: DP Hearing Thursday, June 18, 2009 @2:00 pm., 2154 Rayburn HOB

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B-349B Rayburn HOB
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Mr. KUCINICH. General Fay, we have heard from these witnesses, from Mr. Newman, Mr. Smith, and Mr. Woodson, all about their problems in getting paid by various people. Mr. Newman is the one that had the experience directly with CNA. Would you provide for this committee your internal documents with respect to what your strategies are for denial to increase your corporate profits?

General FAY. We have no such documents that have that kind of a strategy. I wouldn't be associated with a company that had such a strategy.

Mr. KUCINICH. So you are saying that you don't make money denying claims?

General FAY. That is not exactly what I said. I said, Mr. Chairman——

Mr. KUCINICH. Do you agree with that statement? Does CNA make money denying claims?

General FAY. That is not what we are in the business to do. We are in the business to insure people for the risks that we are insuring. When the claims are legitimate claims according to whatever the insurance policy is that we issued to them, then we pay them. We pay them promptly. We pay them according to the law. And we take great pride in doing that.

Mr. KUCINICH. We have testimony that contradicts that. My time has expired but I want to indicate we are going to have a second round. We are going to come back to General Fay and Mr. Moor about the testimony that we are hearing about your claim denials and whether or not you have a conscious strategy as a business to deny claims to people who have been injured or killed in a war.

The Chair recognizes the gentleman, Mr. Jordan.

Mr. JORDAN. I thank the chairman. Let me just begin by thanking all our witnesses, in particular those of you who have been serving our country in a war zone. We certainly appreciate your sacrifice.

Mr. Pitts, you talked about in your testimony problems both with insurers and with the Department of Labor. You had, I thought, some good, practical recommendations in your testimony. Put families on notice that there would be a death benefit in the event that tragedy took place. I think in point No. 4 you talk about frivolous claims.

Mr. PITTS. Actually frivolous defenses. We have always heard about frivolous claims for 10 years but this is a frivolous defense.

Mr. JORDAN. The claimant brings a frivolous case but you also have bad behavior on the part of insurers.

Mr. PITTS. Yes.

Mr. JORDAN. Just as a general question, where is the bigger problem? Is it the lack of oversight? Is it the Government or is it the insurers? You have brought I think you said hundreds of cases. Where do you see the real concern?

Mr. PITTS. There is a defect in the law that needs to be changed. It wouldn't be difficult. Here is what it is: Under the present Code of Federal Regulations, and this is my fifth point, an insurance carrier, not necessarily these gentlemen, but any insurance carrier is in a position where amorally, whatever, it is in their interest to litigate a War Hazards Act case. Under 20 C.F.R. 61.104 they get their litigation costs back. They get their attorneys' fees back and

they get to add 15 percent. You can't get 15 percent in a CD now. You can't get 15 percent assured in the stock market. It is a great deal.

So let us say we have a PTSD case. This has happened, where the claimant's doctor said he has PTSD from the war zone and the insurance company doctor agreed he has PTSD from the war zone. Nonetheless, the case was litigated all the way to completion. There was a judicial finding that yes, this guy has PTSD from the war zone. Within 6 weeks, the War Hazards Act bureaucracy had picked it up and said OK, now you are going to get all your money back. All those litigation costs that the defense had plus they get to add 15 percent. So if it costs $20,000, they get how much? So not only do they have the opportunity to defeat the claim, they drag it out. Who is suffering in this is the guy with PTSD or other kinds of injuries.

So about half of these cases are because of enemy action. They are probably going to get picked up by the War Hazards Act eventually. So if that was modified so they get a handling fee of short term interest rates, which is what these men get, they get about a half of 1 percent. So if that is what they got, and it would fluctuate with times, that would be more appropriate. But as it is, there is a built in incentive for the carrier to profit from litigation.

Mr. JORDAN. How many cases did you say you had handled? I think you said 100?

Mr. PITTS. Well, I have more than 300 going on at any one time over the last 4 years.

Mr. JORDAN. How many of those cases are PTSD?

Mr. PITTS. About 20 percent, which is about the same ratio as the soldiers coming out of the war zone. My most frequent demographic is a truck driver hit by a roadside bomb.

Mr. JORDAN. You were critical in your testimony of the Department of Labor. As I said in my first round with Mr. Harris, this is the second hearing that has dealt with the Department of Labor. This is the first time we have had someone from the Department of Labor come and testify and the person they send has been on the job 3 weeks. With something this important, you would think they would send someone, nothing against Mr. Harris, but send someone who has been on the job a little longer and had a little bit more experience with the critical program. So tell me about your concerns with how the Department of Labor has failed to handle their responsibility.

Mr. PITTS. I think both the Department of Labor Office of Workers' Compensation Program, which is only about, I don't know, 200 or 250 people or so in the country that do this stuff, and the Office of Administrative Law Judges, which is about 40 judges and their staff, have done a great job with the resources they have. The system is not set up so that the OWCP gets to tell anybody anything. They can give recommendations. But if a carrier can litigate and profit off of it, it doesn't do anything.

They give the recommendations; they are ignored. We go into litigation and it takes about a year or so to finally get a judicial decision to enforce. During that time, they are hanging onto the money. And if it is a War Hazards Act claim, they get to get some money, plus the 15 percent. So I think that has been the problem.

If you take that profit motive out of it, that incentive psychologically, subconsciously, or whatever, if you take that out of it and if they can get hit for some penalty of 10 percent or 15 percent for a frivolous defense, found by a judge that this is a frivolous defense, if they can get hit by 10 or 15 percent, it hits their pocketbook. I think that would be reasonable.

Mr. JORDAN. Thank you, Mr. Chairman.

Mr. KUCINICH. I thank the gentleman. The Chair recognizes Mr. Cummings from Maryland. You may proceed for 5 minutes.

Mr. CUMMINGS. Thank you very much, Mr. Chairman. As I sit here and I listen to all of this, it seems that we are talking in two different universes. We have one with these gentlemen who have been harmed and who continue to suffer. Then we have the insurance companies that sound as if they are operating the greatest operation in the world and doing every single thing that they can for these gentlemen. It is a sharp contrast.

To Mr. Moor, according to Los Angeles Times ProPublica story, AIG stopped paying disability benefits to a civilian contractor whose leg was shattered by an insurgent ambush in Baghdad and who suffered from PTSD even though some of your own experts diagnosed him as partially disabled. Further, some 4½ years later in 2008, an Administrative Law Judge ruled that AIG had failed to offer medical evidence to support its position that the contractor's PTSD was not caused by the convoy attack. The article, which was published in April of this year, states that AIG has still not paid Mr. Smith's outstanding medical bills as ordered, I suppose pending AIG's appeal.

My question is this: On what basis is such a determination made? If not on the opinion of AIG's own medical experts, how is the legitimacy of a claim determined? How many claims has AIG denied in which your own expert has sided with the insured?

Mr. MOOR. Congressman Cummings, Mr. Schader would be much more qualified.

Mr. CUMMINGS. We want to hear what he has to say. Nice and loud, please, sir. I want to hear you and these gentlemen want to hear you, too.

Mr. SCHADER. We do agree that there are many changes in this system that would help in its administration and provide a better product faster and quicker. There should be clearer rules for those people who have been hurt overseas as severely as these individuals have been.

I want to make it very clear on behalf of myself as well as of my company that we really do owe them a debt. This is not anything vindictive nor a corporate policy of denial. It is a question of administering programs under an act that is ill-suited.

I have in my written statement submitted at least three fairly detailed areas of reform that would help. I think increasing Labor Department oversight and administration would be of great assistance. Making it more like a State workman's compensation agency would help.

There are some claims that are very, very complex here. We have provided some files to the committee. It is hard almost to the point of impossibility in the few minutes we have to go through the steps of Mr. Smith's claim piece by piece to show why what we did was

right under the benefit levels and the rules that we have to deal with. I have offered to meet with the committee or the staff of the committee. I will bring in any member of my staff to go through those with you and I would be more than happy to do so. If it would aid in the reform of the system and how the benefit levels are calculated, I would be more than happy to do that.

Mr. CUMMINGS. Let me ask you this, the aim of workman's compensation is basically no fault. Is that right? In other words, it is so that the worker can recover once they have an accident or a problem, is that right?

Mr. SCHADER. I absolutely agree with that.

Mr. CUMMINGS. So basically what is happening here is that the insurance is for the purpose of moving a claimant along so that they may be compensated quickly so that the claimant doesn't have to end up having to file suit. That is what workman's compensation was all about. When I was in the State legislature, I was an expert on workman's compensation. I know the Federal may be a little bit different. It seems to me as if AIG is doing just the very opposite of what workman's compensation was supposed to do. It was supposed to expedite claims. It was supposed to give people like Mr. Smith an opportunity to be able to get well and to move forward.

But before you go on and since I have Mr. Smith here, Mr. Smith, what do you think of this testimony? I am just curious. This is your case.

Mr. SMITH. Thank you, sir.

Mr. KUCINICH. The time has expired but the gentleman may respond to the question. Take the time that you need.

Mr. CUMMINGS. Thank you very much, Mr. Chairman.

Mr. SMITH. Thank you, Mr. Chairman and Mr. Cummings. AIG pointed out increasing the funding for the Department of Labor, increasing that area. My question to you, sir, is what good would that do? You don't listen to what they say anyway. I have documented proof where AIG has ignored the recommendations of the Department of Labor. Then we have to continue to go through litigation again and again and again and again. So the Department of Labor is fine, sir. Your company is not.

Mr. CUMMINGS. Thank you, Mr. Chairman.

Mr. KUCINICH. We will permit AIG to respond briefly.

Mr. SCHADER. We have not been sitting on Mr. Smith's claim, refusing to pay, and making arbitrary decisions.

Mr. KUCINICH. Mr. Smith.

Mr. SMITH. Sir, I have documentation otherwise.

Mr. KUCINICH. Do you want to submit documentation to this committee?

Mr. SMITH. It is in my statement.

Mr. KUCINICH. OK. Mr. Schader.

Mr. SCHADER. I would like to add that we have paid over $500,000 on Mr. Smith's case in medical and indemnity to date. There are no medical bills outstanding today.

Mr. KUCINICH. Was that the total of your bills, Mr. Smith?

Mr. SCHADER. That is indemnity as well.

Mr. SMITH. So, sir. That was not the total. That is a falsification. They have not paid my doctors in full. They have paid what they thought was acceptable. I have proof, I have documentation where

they paid for services on a particular date. When they cut the check to the doctor, it was less than half and in some cases just a small percentage of what was actually owed. If he wants to ask me about it, I have that documentation and I will provide that to the committee.

Mr. KUCINICH. Now, do you have that documentation, Mr. Schader?

Mr. SCHADER. I don't have it and I would be more than happy arrange a meeting with Mr. Smith.

Mr. KUCINICH. Do you want to give it to him right now? Do you have copies of that? If that is in the record, since Mr. Smith is referencing it, Mr. Schader is entitled to copies of it.

Mr. SMITH. I would like to add in addition——

Mr. KUCINICH. If you want to examine those, examine them and if you want to comment on them later you will be permitted to do that.

Mr. SCHADER. Thank you.

Mr. KUCINICH. OK, so we are going to move on. You will get a chance to respond. But I think you ought to examine the documents that he gives you and then you can respond. We will make sure you get the chance to do that. We are going to go to the second round of questions, here.

Mr. SMITH. Mr. Chairman, I apologize to the committee. I will make that available within the next 24 hours.

Mr. KUCINICH. You are saying you don't have it with you right now?

Mr. SMITH. No, sir. I left it in the hotel room.

Mr. KUCINICH. Please make it available and then we will get it to Mr. Schader. Then we will send further questions from the subcommittee to you so that you have a chance to answer them in light of what Mr. Smith has said. Is that fair?

Mr. SCHADER. We would be more than happy to do that. Yes, absolutely.

Mr. SMITH. Thank you.

Mr. KUCINICH. OK, I want to get back to the line of questioning that I was working on. General Fay, you testified that CNA's average yearly profits for all of its Defense Base Act insurance from 2002 to 2007 was——

Excuse me and I apologize. The gentlelady from California, Ms. Watson, is entitled to 5 minutes of questions. I want to thank the gentlelady. Please proceed.

Ms. WATSON OF CALIFORNIA. Thank you so much, Mr. Chairman. I know you are on a roll here.

Mr. KUCINICH. No, the gentlelady is entitled to 5 minutes. Go ahead, please go ahead.

Ms. WATSON OF CALIFORNIA. You are going down the same line I would go down. But I want to thank the gentleman who had been out protecting our country for coming here in such a civil way and explaining what has happened to you. I think it is reprehensible that the insurance companies would hold up or delay. I think your kinds of cases should be No. 1. To have to come here and testify in public to get the insurance company to take a deeper look at your request I think is just an injustice to those of you who have

been securing our own country. So thank you for being here. Thank you for your patience.

Listening to your testimony, if you cannot be compensated for your wounds both emotional and physical, I don't suspect contractors' families get any compensation for what they have suffered. I will direct this to Mr. Pitts. I know that in our U.S. Government contractors and subcontractors law there was no reference to a contractor's family members or dependents except for the instance of compensation benefits for survivors of covered workers who were killed on the job. Is there any way to assist the families and the loved ones of these victims?

Mr. PITTS. Beyond the death benefits, Congresswoman?

Ms. WATSON OF CALIFORNIA. Yes, beyond the death benefits. Those that are alive.

Mr. PITTS. Well, I think if their husbands were taken care of correctly, that would be the best benefit.

Ms. WATSON OF CALIFORNIA. But there is no benefit?

Mr. PITTS. No, there is no benefit. Unless a contractor dies as a result of his work over there, there are no benefits that go to the surviving spouse or the minor children.

Ms. WATSON OF CALIFORNIA. So they would have to seek private insurance. When these gentlemen come home, there is care that has to be given. There are services that have to be given, food, clothing, and shelter. So there is no way for them to be covered for these expenses?

Mr. PITTS. In rare instances there have been cases where I have been able to get some compensation for, let us say, a wife that has to leave her job to come home to take care of her husband because he is so badly injured he can't take care of himself. So there have been cases where we have been able to get compensation through the judges to do that.

Ms. WATSON OF CALIFORNIA. I was listening very closely to your recommendations of how we should close these gaps. Mr. Chairman, we might from this subcommittee and our hearings want to recommend legislation and policy that will not only cover the victims themselves but their families as well. I don't care whether they have to work and come home, it still is a burden on them to have someone who has not been compensated for their illnesses. Their providers have not been compensated fully yet. So I think that this is something, Mr. Chairman, that could grow out of the testimony here.

I would think that all of those recommendations that you made should include compensation. I think they were in your testimony, the recommendations, Mr. Pitts?

Mr. PITTS. Yes, it is the second one about making sure the widow knows that there is such a thing as the Defense Base Act and that she may have a claim for her family. I am afraid otherwise there are going to be some real injustices out there because they just don't know any better.

If you are in a small town in Texas, your husband is a truck driver. He goes to work to support the troops over there. He dies. So what is the chance that you are going to figure out there is such a thing as the Defense Base Act and to fill out the right death claim to file it with the New York office in a timely way?

That is just a gap that shouldn't be. The employer should have some obligation to get her acknowledgment she has been told about this. I think that is reasonable.

Ms. WATSON OF CALIFORNIA. The gentlemen to your left, are they your clients?

Mr. PITTS. No. Toby Cole, who is an attorney in Houston also.

Ms. WATSON OF CALIFORNIA. What I would like to see you do, and you gentlemen, too, is recommend to us how we can better the system so that benefits can reach out to the people they are intended to. These are contractors. They might not have been fighting but they were in theater. We owe them that.

I have been with insurance companies and there is a point at which they just kick you out because your claims have been too large. I have been through that myself. But we want to improve the system. Particularly with this bogus war that we fought over in Iraq, these gentlemen went over to assist. They shouldn't be treated like this after their severe injuries.

So this hearing is to collect the information. I hope, Mr. Chairman, that we will end up with some recommendations to put into a policy. With that, I yield back. I already have the red light. Thank you, Mr. Chairman.

Mr. KUCINICH. The Chair will begin the second round of questioning for 5 minutes.

Ms. WATSON OF CALIFORNIA. Would you yield for just a second?

Mr. KUCINICH. I yield to the gentlelady.

Ms. WATSON OF CALIFORNIA. You were consulting with staff. I would hope that out of our hearings would grow some policy that we can give to the full committee dealing with insurance and insurance claims and so on.

Mr. KUCINICH. Our role as a Committee on Oversight and Government Reform, we do oversight and reform. So we will work with the gentlelady, with the Ranking Member Jordan, with Mr. Cummings, and with every member of this committee because we do want to change this. There is no question about it. But before you change it, so that you know the direction you are going, you have to find out what happened. We have to do some forensics here and the forensics may not be pretty.

General Fay, you have testified that CNA's average yearly profits for all its Defense Base Act insurance from 2002 to 2007 was 14.6 percent and only 9 percent from 2009. Isn't it true, however, that you have failed to mention that CNA's profits for all of its Department of Defense Defense Base Act business, where CNA contracts directly with Defense contractors, the business under scrutiny today, that those profits are over 50 percent per year? That is based on documents that were produced for this committee and I believe were obtained from you.

General FAY. Yes, chairman. The truth of the matter, the facts are that on non-program business, we at CNA agree with all the recommendations that is the line of business that should be changed. In fact, the DBA program should be written under a program business.

Mr. KUCINICH. But when you said 14 percent, I just want to clarify the record here because it is about numbers. You gave some numbers in your testimony. You said it is only 14 percent. Isn't

that the profit number for all of your DBA business including the single risk pool programs with agencies other than DOD?

General FAY. Yes, that is correct. It is all of them taken together.

Mr. KUCINICH. Thank you. OK. I just want to make sure that we put that in the record. Without objection, we will enter the record statement and the records from CNA which state that a projected combined ratio for profit was 50 percent.

General FAY. That is on the non-program business only. That is only 3 percent of the market.

Mr. KUCINICH. Thank you. That is the subject of this hearing. You are getting 50 percent profit. We are hearing some witnesses who may give us an idea why you have 50 percent profit.

General FAY. We agree it should be changed.

Mr. KUCINICH. Now with AIG, Mr. Schader, you have touted AIG's handling of your PTSD claims in your testimony and in documents provided to the subcommittee. Yet are you aware that AIG has repeatedly utilized the expert testimony of a psychiatrist to review and ultimately reject PTSD claims of insured civilian contractors who were injured who freely and repeatedly admits both under oath and to reporters that he is neither an expert on PTSD nor on MMPI–2?

Mr. SCHADER. No, I am not sure who you are referring to.

Mr. KUCINICH. Actually, are you an expert on PTSD?

Mr. SCHADER. No, I am not. As a matter of fact, there is one thing I do want to say about that. I had talked to the Labor Department about 2½ years ago about sharing and reaching out for expert assistance from the VA, who I think does have the best cadre of experts. I do want to say, it may surprise Mr. Pitts, but I actually endorse completely his recommendation on the handling of PTSD cases.

Mr. KUCINICH. Mr. Pitts, have you had experience with Dr. Griffith?

Mr. PITTS. Yes.

Mr. KUCINICH. Do you want to tell us about that experience?

Mr. PITTS. Basically, the vast majority of people that he has seen he says don't have PTSD. He has reservations about whether there is such a thing.

Mr. KUCINICH. Did he repeatedly find, in your experience, that claimants were malingerers?

Mr. PITTS. Normally.

Mr. KUCINICH. Do they use real experts in evaluating PTSD?

Mr. PITTS. Dr. Griffith has said that he is not an expert in the MMPI–2, which is the Minnesota Multiphasic Personality Inventory. It is sort of a psychological battery that the courts are relying on.

Mr. KUCINICH. Do you employ Dr. Griffith, Mr. Schader?

Mr. SCHADER. Yes, we do.

Mr. KUCINICH. Don't you think you should be employing a real expert in this illness rather than a self described non-expert?

Mr. SCHADER. I would like the opportunity to send to the committee Dr. Griffith's credentials. I don't agree that he is not an expert in this area.

Mr. KUCINICH. Is he a skeptic of mental illness?

Mr. SCHADER. I don't believe so.

Mr. KUCINICH. Then how do you explain the number of denials that you have had in claims for PTSD?

Mr. SCHADER. PTSD is a very difficult phenomenon to diagnose and prescribe treatment for. Even when it exists, it doesn't always prohibit or inhibit somebody from holding gainful employment.

Mr. KUCINICH. This subcommittee, if it hasn't already, will ask AIG for its records on the rate of denials of claims for PTSD. We will also ask both CNA and AIG for information, internal documents, memoranda, and emails relating to the relationship between your claim denials and your profits. So you will be getting a formal letter from the committee. I just want to let you know right now that will be coming.

The Chair recognizes the gentleman from Ohio, Mr. Jordan.

Mr. JORDAN. Thank you, Mr. Chairman. Mr. Moor or Mr. Schader, what percentage of the claims that you receive are PTSD claims?

Mr. SCHADER. We don't have precise numbers on that because we don't track that as a characteristic. I would estimate it at about 20 percent of the serious cases.

Mr. JORDAN. The same percent that Mr. Pitts said for the type of cases he brings. So is that consistent with you, too, Mr. Fay?

General FAY. I am sorry but I really do not know what the percentage is. I just know that on those very few cases that went to Administrative Law Judges only two of them were PTSD. We prevailed in one and the claimant prevailed in one.

Mr. JORDAN. OK. Let me change gears here. One of the questions I have in front of me, it has been alleged that companies are denying claims for fear that they will not be reimbursed under the War Hazards Compensation Act. Is there any truth to that? Have you had any situations where the Government hasn't reimbursed you for a war related injury?

Mr. SCHADER. We have submitted about $42 million of claims that we had paid before certification under the War Hazards Compensation Act. To this date we have only received $3 million.

Mr. JORDAN. Wow. Has that impacted your decision in how you have handled the claims that come in front of you?

Mr. SCHADER. No.

Mr. JORDAN. Mr. Pitts.

Mr. PITTS. The War Hazards Act people are actually a small group. We are talking four or five people in Ohio. Their job is basically to protect the taxpayer from bad War Hazards Act claims. So they are sort of skeptics. If there is a gray area, they are going to deny the claim, or there is an impetus to. That makes sense; that is their job.

However, PTSD by its nature you could say is fuzzy. So it is something that would make sense if you were an insurance company. You have this fuzzy claim and you want to get your money back. Drag it out. Litigate it. If you lose, there is going to be a judicial holding that this is from the war. Then you know you are going to get your money back. Then you also get to turn in your attorneys' fees and get the 15 percent. So that is what is going on, I mean from my point of view. That is my opinion.

Mr. JORDAN. Mr. Pitts, let me stick with you on an issue that I brought up earlier and that I think coincides with your testimony.

You suggest employers get a signed, written statement and put families on notice about DBA benefits. Dyncorp has this Civilian Police Employee Assistance Program. What are your thoughts on that kind of a program? Is that something we should encourage and the Department of Labor should encourage with contractors the Government is doing business with?

Mr. PITTS. KBR also has the Employee Assistance Program to some part of the war, I think, where they were paying for like eight visits or something to a psychologist. I am not sure if they are still doing that. I see so many people. OK, so in some instances they were doing something like that. Dyncorp, I have to say, was proactive about PTSD and some of the other things. I really think they deserve some credit for that.

Mr. JORDAN. Mr. Newman, would you like to comment?

Mr. NEWMAN. Yes, sir. We started a simple Employee Assistance Program for several reasons. It was to bridge the gap with the insurance carriers because we thought the gap was bridgeable. In reality, even the requests that we would make of the insurance carriers oftentimes were totally ignored.

But I was discussing with a colleague, actually from Dyncorp—he was here earlier today—about that issue of almost a national Employee Assistance Program or something to that effect or of encouraging the employers, not the insurance companies, to have that type of program.

At Dyncorp we have a psychological staff that, regardless of whether it is a covered claim or what, they still provide some psychological services for Post-Traumatic Stress.

I do want to comment on Post-Traumatic Stress. I disagree that it is fuzzy. It is pretty clear when you actually see it.

Mr. PITTS. Can I clarify that on the fuzzy? What I mean is legally fuzzy in the sense that the insurance company can always say well, it is personal problems. How do we know it comes from the war? They are afraid that the War Hazards people are going to see it as fuzzy and deny their claim. So it hedges their bets tremendously to just go ahead and litigate all that stuff out, which is bad on the country. It increases costs. It is just wrong. But that is why structurally it is happening.

Mr. NEWMAN. Yes, sir. I want to apologize to Mr. Pitts for referring you to his comment of fuzzy. I was more referring to the comments of malingering, etc.

Mr. JORDAN. I knew what you meant. It is just the lawyers who get nervous. I knew what you meant. [Laughter.]

Thank you, Mr. Chairman.

Mr. KUCINICH. I thank the gentleman. The Chair recognizes Mr. Cummings for 5 minutes.

Mr. CUMMINGS. Mr. Chairman, I don't think I am going to use all my time. I just want to say to you, Mr. Newman, Mr. Smith, and Mr. Woodson, I want to thank you for your service. Sometimes I think people can get confused and not do everything that they are supposed to do for people who give so much. We have to straighten out this mess. You heard Mr. Seth Harris say that we have major problems and that they need to be corrected. You even heard some of these witnesses imply that, at least.

I know how you feel, Mr. Pitts, but I know how some of my other witnesses feel, too. We have to straighten this out. We are going to do that. Because we can't be in a situation where you continue to suffer and get no real relief and the beat goes on. The AIGs of the world continue to get their bonuses and go on their junkets. The CNAs, no matter what the General may say, goes on doing their thing. But then you are left to suffer. We can do better than that.

We are a better country than that, particularly when you consider the fact that the hard earned dollars of our constituents are paying into these insurance companies and they cannot lose. You understand that. The way this thing is structured, they can't lose. It makes it almost criminal, the idea that get our money. That is No. 1. Then they are supposed to take care of you and if they don't then they don't. Then you suffer and they get rich. Boy, what a game. What a game.

So in some kind of way, we have to turn this around. We have a very committed chairman of our full committee, Mr. Towns. We have a very dedicated and hard working and just a strong chairman of this subcommittee, Mr. Kucinich. I know we will have our rankings hopefully joining in. Because this is an American problem. This is not Republican and Democrat. This is American.

I mean, if you are talking about being patriotic, this country takes care of its own. We have become the great country that we are because of our moral authority, not so much the military authority. It may back up the moral, but it is the moral authority. One part of moral authority is that you take care of your own, period.

So I want to thank you for your testimony. Mr. Chairman, I will yield back on that.

Mr. KUCINICH. I thank the gentleman. The Chair recognizes the gentlelady.

Ms. WATSON OF CALIFORNIA. Mr. Chairman, I just have to read part of my opening statement because I think it goes right to the reason why we had this hearing.

In 2008, there were 200,000 civilian contractors in Iraq and Afghanistan. There were more civilian contractors than there were U.S. troops in both combat theaters combined. The contractors' presence in these combat zones goes primarily under the radar. Very little is reported on the number of injuries they sustain due to the service they provide in aiding the Federal Government in its mission. As of June 2008, more than 1,350 contractors have died in Iraq and Afghanistan. There were another 29,000 injured. More than 8,300 of those were serious, permanent injuries.

So as the number of Defense Base Act claims for compensation due to injury of death of a contractor rises, the payments on the amount of compensation, the benefits paid per claim have dropped to their lowest level since 2003. I am wondering how this can be with the high levels of injuries that are being sustained by contractors themselves.

Mr. Smith, I don't understand "ignored." How could they ignore the claim? Could you explain what you mean by "ignored?"

Mr. SMITH. Yes, ma'am. The Department of Labor would make a finding at an informal hearing. That is the first step in the proc-

ess of litigation. I am sorry, ma'am, but I don't know any other way to put it. They absolutely ignore the Department of Labor findings.

Ms. WATSON OF CALIFORNIA. The Department of Labor then?

Mr. SMITH. Yes, ma'am.

Ms. WATSON OF CALIFORNIA. I want you to know Secretary Solis said there is a new sheriff in town.

Mr. SMITH. Yes, ma'am. I understand that and I am proud to hear that. I thank this committee for stepping up and taking the ball. But in my case, that is exactly what has happened. In my opening statement, I have the proof in the documentation.

Ms. WATSON OF CALIFORNIA. Yes, well I hope that you will share those papers and your documentation with Mr. Schader and Mr. Moor.

Mr. SMITH. Yes, ma'am. I will provide that to this committee.

Ms. WATSON OF CALIFORNIA. Thank you. As soon as possible.

Mr. SMITH. Within 24 hours, ma'am.

Ms. WATSON OF CALIFORNIA. Thank you. With that, I will defer the rest of my time, Mr. Chairman, to you.

Mr. KUCINICH. I thank the gentlelady. The committee has submitted for the record information that AIG had a net earned premium from the Government of $1.3 billion from 2002 to 2007 and underwriting gains of $500 million, a 38 percent gain.

Now, Mr. Woodson, you lost a leg and you lost almost all of your eyesight?

Mr. WOODSON. I lost the sight of my left eye, three fourths of my right, and I lost my left leg. At the present time, I am using a magnifier to try to read. AIG will not even pay for the glasses that the doctor ordered back in April.

Mr. KUCINICH. Net earned premium of $1.3 billion and underwriting gains of $500 million, a 38 percent gain. Mr. Moor, when you hear this, do you feel any sense of regret or concern about what Mr. Woodson has gone through? How does this make you feel?

Mr. MOOR. Mr. Chairman, there is no doubt that when you hear something like this, with any of these gentlemen, and know what they have done in serving the country that you do have a feeling toward them. My job is to make sure that we are doing everything that we possibly should do and that we are obligated to do under the current regulations in the laws to provide the right care for these individuals. That is what Mr. Schader——

Mr. KUCINICH. You are telling Mr. Woodson that you did everything you could for him. Is that what you are telling him? Is that your testimony?

Mr. MOOR. I haven't personally done everything I can for him. I don't know.

Mr. KUCINICH. Has your company, AIG, done everything it could? Is that your testimony?

Mr. SCHADER. The answer is yes. It is everything that we could have done. Just as an example, and I don't know where the communication is failing, but on the glasses prescription that was written and submitted to us on April 28, 2009, it was approved the same day.

Mr. WOODSON. They have never paid for it. They still have the glasses.

Mr. KUCINICH. Mr. Woodson, you say they never paid for it?

Mr. WOODSON. They never have paid for it.

Mr. KUCINICH. See, this is the reason why we brought these witnesses here. These are people who are part of the hundreds of thousands of contractors who are insured through a variety of companies with the Government making sure that you get money to pay claims. What happens when insurance companies don't pay claims? Typically, their profits are higher. That is our concern here.

Our concern as a committee is Mr. Newman, who lost a leg; Mr. Smith, who suffers from PTSD; and Mr. Woodson, who lost most of his eyesight and has a prosthetic leg. Each and every one of them represents not just the three of them but stands for many more who served America as private contractors, who were injured and sometimes killed, and who cannot get any justice. Look, if you are the insurance company and you deny a claim, they are already at a disadvantage to fight you. If you defer paying a claim, you can drag it out.

How long did it take you, Mr. Newman, to get your new prosthetic leg?

Mr. NEWMAN. The newest one, it took over 550 days.

Mr. KUCINICH. Over 550 days. Is that acceptable? It can't be acceptable.

The committee is going to go further into this, I just want you to know. We are going to have to move on to votes here. Every person here who was asked to testify will be continuing to stay in touch with the committee and the committee with you. You all will be given a chance to get your testimony into the record of this hearing. But we are going to pursue this more.

These three gentlemen, with the grievous injuries that they have suffered, came here in front of a congressional committee and took an oath to their testimony. Then we find out that there is this disconnect between payment of their claims and satisfying them so their lives can be made whole.

Let me just tell you something, you gentlemen, General Fay, Mr. Moor, and Mr. Schader, you are going to walk out of here with your two natural legs. You are going to walk out of here not needing assistance to see where you are going. You are going to go home and you won't be troubled by flashbacks about combat. You don't have to contend with what these gentlemen have had to contend with and what many others who served the country as contractors have had to contend with. So that is why we are holding these hearings. This isn't about you personally, but you stand for institutions that we have to find a way to make more responsive.

The gentlelady's time has expired. I am going to just wrap this committee meeting up, putting into the record that CNA's net earned premiums from 2002 to 2007 were $110,722,000. Their underwriting claims were $58 million. Their percent of gain was 53 percent. We have others that are involved, too.

I want to put into the record this memorandum from staff. It is an exchange regarding the source of a majority memorandum that was referenced by Mr. Fay in his testimony. This committee operates under rules of the House and the rules are pretty strict with respect to the gathering of information and the production of records.

Major General Fay, a witness for CNA, made explicit reference to the majority staff's memorandum to Members, which is a non-public document prepared for subcommittee members in advance of a hearing. Chairman Kucinich, and this was prepared by the staff here just now, asked General Fay how he obtained a copy of the committee memorandum. General Fay responded that a member of his legislative staff provided it to him. She and a colleague were identified and approached the witness table. Heather Davis was sworn in.

When asked how she obtained the majority's memorandum, Ms. Davis said that General Fay may have been in error and that the source to him of the memorandum was either herself or her male colleague. She said that she obtained the memorandum from committee staff. She was asked if it was a Democratic committee staff member who provided the memo. The male colleague responded that it was not a Democratic committee staff member who gave the committee memorandum to CNA.

While this is essentially an internal matter, it was made external because of the fact that you, General Fay, received information that rightfully should not have been in your possession. We will investigate that further. Our attorneys will be in touch with you and your staff regarding this matter.

I also want to say that in response, and by the way, I want the majority staff to know that I showed Mr. Jordan these remarks that I am about to read into the record, in response to the comment of the ranking member, I would like to correct the record. The majority has extended the customary accommodations to the minority including the subject of the hearing, a detailed briefing memorandum on the subject matter, the contact information of all witnesses, and the right to invite a witness.

If the minority had difficulty preparing its Members for this hearing in spite of this considerable assistance, then we look forward to working with you to try to find out how we can make this work for you. We value your cooperation and we want to make sure that you have every opportunity to prepare for these hearings in a way that you feel is important for those that you serve. I value you greatly, the work of the staff on both sides.

I want to thank each and every witness here. As difficult as it was for CNA and for AIG to be here, we do need your help in trying to straighten this out.

This is not simply a private sector matter. I just spent the last 6 years trying to get the Defense Finance and Accounting Service from a privatization program that Lockheed Martin had that was similarly denying people their claims for whatever reason. So this is something that we see some systemic problems with. In our detailed conversations with Lockheed Martin, we found that the best solution for them was simply to give the business back to the Government, which I think they were glad to do because they weren't making money on it. At least, they weren't making as much money as you are.

I want to thank again Mr. Newman, Mr. Smith, and Mr. Woodson for your service to the country. Your presence here represents a lot of people who were private contractors who served. I think that everyone here, whatever their position on this dais and what-

ever their position in the audience, appreciates that you served and appreciates the price that you paid. I think everybody is going to take a renewed interest. I would hope that a renewed interest is going to be taken in your situation but then expands to the larger question. Mr. Pitts, thank you for your service as well.

Again, I want to thank the witnesses. We will be in touch with all of you.

Ms. WATSON OF CALIFORNIA. Would you yield for a second?

Mr. KUCINICH. I will yield to the gentlelady, of course.

Ms. WATSON OF CALIFORNIA. The reason why I read some paragraphs from my opening statement is because I stated some of the numbers. We will submit that, too, to go along with the report so we will have the numbers.

Mr. KUCINICH. The record of this hearing will remain open for five legislative days. The gentlelady's submission will be valued and gratefully received. I just want to make sure that I submitted this for the record, this calculation of profits that is from CNA.

Ms. WATSON OF CALIFORNIA. Thank you. I yield back.

Mr. KUCINICH. I thank the gentlelady. I also thank her for her willingness to work with us in crafting a legislative solution. The representative from the Department of Labor said it is really up to us. We really do have a responsibility here to look at this legislatively. We are going to.

This is the Domestic Policy Subcommittee. I am Dennis Kucinich, chairman of the subcommittee. It is a Subcommittee of Oversight and Government Reform. This has been a hearing that has dealt with the issues of claims not being paid, the reasons why that could happen, and what could be done in the future to rectify that. I want to once again thank all the witnesses for their appearance. We will continue to be in touch with you.

This committee stands adjourned. Thank you.

[Whereupon, at 9 p.m., the subcommittee was adjourned.]

[Additional information submitted for the hearing record follows:]

ONE HUNDRED ELEVENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

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WASHINGTON, DC 20515–6143

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July 14, 2009

Mr. Thomas F. Motamed
Chairman and CEO
CNA Financial Corporation
333 S. Wabash
Chicago, Illinois 60604

General George R. Fay
Executive Vice President
Worldwide P&C Claim
CNA Financial Corporation
333 S. Wabash
Chicago, Illinois 60604

Dear Mr. Motamed and General Fay:

In connection with the Domestic Policy Subcommittee of the Oversight and Government Reform Committee's hearing on June 18, 2009, "After Injury, the Battle Begins: Evaluating Workers' Compensation for Civilian Contractors in War Zones," the Subcommittee submits the following questions for the hearing record:

1) A recent Department of Defense Inspector General audit found that military hospitals were not billing and collecting payment from contractors or their insurance providers for health care provided to their employees, and as a result these military treatment facilities have been burdened by the costs of providing free medical care to civilian contractors.[1] What steps has CNA taken to make sure that military facilities are reimbursed for the care provided by military hospitals to civilian contractors?

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[1] Army Audit Agency, *Audit of Defense Base Act Insurance for the Logistics Civil Augmentation Program, Audit of Logistics Civil Augmentation Program Operations in Support of Operation Iraqi Freedom* (Sept. 28, 2007) (A-2007-0204-ALL), available at http://s3.amazonaws.com/propublica/assets/contractors/dodig_health_care_contractors_090504.pdf.

2) For the period 2002 to the present, how many claims has CNA denied in which CNA's own medical expert has sided with the claimant? What is CNA's policy with respect to fighting claims in which its doctors agree with the claimant's doctors regarding injury and disability?

3) What actions does CNA take to determine the qualifications of experts CNA uses to evaluate and contest PTSD claims?

4) For the period 2002 to the present, what percentage of claims for treatment and benefits related to PTSD has CNA paid-in-full, paid in part, and denied outright?

5) For the period 2002 to the present, what percentage of claims that CNA has submitted to the Department of Labor (DOL) for reimbursement under the War Hazards Act have been granted by DOL? What is the total dollar amount of claims submitted to DOL for reimbursement under the War Hazards Act? What is the total dollar amount that CNA has been reimbursed from DOL for War Hazards Act claims?

6) For the period 2002 to the present, what percentage of claims has CNA sought an Administrative Law Judge (ALJ) ruling to determine whether a claim falls under the War Hazards Act? Does CNA believe it needs a ruling by an ALJ stating that a claim falls under the War Hazards Act in order to apply for reimbursement from DOL?

7) Does CNA notify the Department of Defense or Department of Labor when a contract firm cancels a Defense Base Act workers' compensation insurance policy?

8) What steps has CNA taken to make sure that the foreign subcontractors it insures report worker injuries? What steps has CNA taken to educate foreign nationals working for contractors or subcontractors on their rights to benefits under the DBA?

9) General Fay testified that with the 5500 or so claims filed with CNA in the past seven years, CNA "believe[s] that we have only gone to an administrative ruling in fewer than 20 cases." During the subcommittee's investigation, CNA's Deputy General Counsel represented to subcommittee staff that it does not routinely track data on how many claims are disputed; how many go through dispute resolution process with DOL; or how many are adjudicated by an ALJ. *(See attached email)*. Where and how did you obtain this data provided in your testimony? Did CNA manually review the files?

10) CNA has emphasized throughout this Subcommittee's investigation that it has a very small percentage of market share for the "non-program" DBA business. Why doesn't CNA have more market share? Has CNA attempted to capture more of the "non-program" DBA business?

11) For the period 2002 to the present, how much does CNA spend per year litigating disputed DBA workers' compensation claims?

12) For the period 2002 to the present, how many claims of which CNA originally denied has CNA been ordered by an ALJ to provide compensation to the claimant? What is the total dollar amount CNA has paid to claimants as a result of ALJ rulings?

13) Please provide a detailed explanation of the status of indemnity payments being made to Mr. Timothy Newman and the basis for which CNA is disputing its past and future weekly indemnity payments to Mr. Newman.

14) DOL has testified that it holds informal hearings to try to resolve disputes between carrier and contractor, and provide recommendations, sometimes urging the carrier to pay the claimant.

   a. Have your claims adjusters ever ignored recommendations made by a DOL administrator during these informal resolution proceedings?

   b. On how many occasions?

   c. Who makes the determination to ignore a recommendation made by DOL? Is this company policy?

15) What is the single most important reform that you believe is needed to improve your companies' ability to provide fair and comprehensive benefits to your claimants?

The Oversight and Government Reform Committee is the principal oversight committee in the House of Representatives and has broad oversight jurisdiction as set forth in House Rule X. An attachment to this letter provides information on how to respond to the Subcommittee's request.

We request that you provide these documents as soon as possible, but in no case later than **5:00 p.m. on Wednesday, August 5, 2009**.

If you have any questions regarding this request, please contact Claire Coleman, counsel, at (202) 225-6427.

Sincerely,

Dennis J. Kucinich
Chairman
Domestic Policy Subcommittee

cc: Jim Jordan
Ranking Minority Member

Domestic Policy Subcommittee Document Request Instruction Sheet

In responding to the document request from the Domestic Policy Subcommittee, Committee on Oversight and Government Reform, please apply the instructions and definitions set forth below.

Instructions

1. In complying with the request, you should produce all responsive documents in your possession, custody, or control.

2. Documents responsive to the request should not be destroyed, modified, removed, transferred, or otherwise made inaccessible to the Subcommittee.

3. In the event that any entity, organization, or individual denoted in the request has been, or is currently, known by any other name than that herein denoted, the request should be read also to include them under that alternative identification.

4. Each document produced should be produced in a form that renders the document capable of being copied.

5. When you produce documents, you should identify the paragraph or clause in the Subcommittee's request to which the documents respond.

6. Documents produced in response to this request should be produced together with copies of file labels, dividers, or identifying markers with which they were associated when this request was issued. To the extent that documents were not stored with file labels, dividers, or identifying markers, they should be organized into separate folders by subject matter prior to production.

7. Each folder and box should be numbered, and a description of the contents of each folder and box, including the paragraph or clause of the request to which the documents are responsive, should be provided in an accompanying index.

8. It is not a proper basis to refuse to produce a document that any other person or entity also possesses a nonidentical or identical copy of the same document.

9. If any of the requested information is available in machine-readable or electronic form (such as on a computer server, hard drive, CD, DVD, memory stick, or computer backup tape), you should consult with Subcommittee staff to determine the appropriate format in which to produce the information.

10. The Committee accepts electronic documents in lieu of paper productions. Documents produced in electronic format should be organized, identified, and indexed electronically in a manner comparable to the organizational structure called for in (6) and (7) above. Electronic document productions should be prepared according to the following standards:

    (a) The production should consist of single page TIF files accompanied by a Concordance-format load file, an Opticon reference file, and a file defining the fields and character lengths of the load file.

    (b) Document numbers in the load file should match document Bates numbers and TIF file names.

    (c) If the production is completed through a series of multiple partial productions, field names and file order in all load files should match.

11. In the event that a responsive document is withheld on any basis, you should provide the following information concerning the document: (a) the reason the document is not being produced; (b) the type of document; (c) the general subject matter; (d) the date, author, and addressee; and (e) the relationship of the author and addressee to each other.

12. If any document responsive to this request was, but no longer is, in your possession, custody, or control, you should identify the document (stating its date, author, subject and recipients) and explain the circumstances by which the document ceased to be in your possession, custody, or control.

13. If a date or other descriptive detail set forth in this request referring to a document is inaccurate, but the actual date or other descriptive detail is known to you or is otherwise apparent from the context of the request, you should produce all documents which would be responsive as if the date or other descriptive detail were correct.

14. This request is continuing in nature and applies to any newly discovered document. Any document not produced because it has not been located or discovered by the return date should be produced immediately upon location or discovery subsequent thereto.

15. All documents should be bates-stamped sequentially and produced sequentially. In the cover letter, you should include a total page count for the entire production, including both hard copy and electronic documents.

16. For paper productions, four sets of documents should be delivered: two sets to the majority staff and two sets to the minority staff. For electronic productions, one dataset to the majority staff and one dataset to minority staff are sufficient. Productions should be delivered to the majority staff in B-349B Rayburn House Office Building and the minority staff in B-350A Rayburn House Office Building. You should consult with Subcommittee staff regarding the method of delivery prior to sending any materials.

17. Upon completion of the document production, you should submit a written certification, signed by you or your counsel, stating that: (1) a diligent search has been completed of all documents in your possession, custody, or control which reasonably could contain responsive documents; and (2) all documents located during the search that are responsive have been produced to the Subcommittee or identified in a privilege log provided to the Subcommittee.

Definitions

1. The term "document" means any written, recorded, or graphic matter of any nature whatsoever, regardless of how recorded, and whether original or copy, including, but not limited to, the following: memoranda, reports, expense reports, books, manuals, instructions, financial reports, working papers, records notes, letters, notices, confirmations, telegrams, receipts, appraisals, pamphlets, magazines, newspapers, prospectuses, interoffice and intra-office communications, electronic mail (email), contracts, cables, notations of any type of conversation, telephone calls, meetings or other communications, bulletins, printed matter, computer printouts, teletypes, invoices, transcripts, diaries, analyses, returns, summaries, minutes, bills, accounts, estimates, projections, comparisons, messages, correspondence, press releases, circulars, financial statements, reviews, opinions, offers, studies and investigations, questionnaires and surveys, and work sheets (and all drafts, preliminary versions, alterations, modifications, revisions, changes, and amendments of any of the foregoing, as well as any attachments or appendices thereto). The term also means any graphic or oral records or representations of any kind (including without limitation, photographs, charts, graphs, voice mails, microfiche, microfilm, videotape, recordings and motion pictures), electronic and mechanical records or representations of any kind (including, without limitation, tapes, cassettes, disks, computer server files, computer hard drive files, CDs, DVDs, memory sticks, and recordings), and other written, printed, typed, or other graphic or recorded matter of any kind or nature, however produced or reproduced, and whether preserved in writing, film, tape, disk, videotape or otherwise. A document bearing any notation not a part of the original text is to be considered a separate document. A draft or non-identical copy is a separate document within the meaning of this term.

2. The term "documents in your possession, custody, or control" means (a) documents that are in your possession, custody, or control, whether held by you or your past or present agents, employees, or representatives acting on your behalf; (b) documents that you have a legal right to obtain, that you have a right to copy, or to which you have access; and (c) documents that you have placed in the temporary possession, custody, or control of any third party.

3. The term "communication" means each manner or means of disclosure or exchange of information, regardless of means utilized, whether oral, electronic, by document or otherwise, and whether face-to-face, in a meeting, by telephone, mail, telexes, discussions, releases, personal delivery, or otherwise.

4. The terms "and" and "or" shall be construed broadly and either conjunctively or disjunctively to bring within the scope of the request any information which might otherwise be construed to be outside its scope. The singular includes plural number, and vice versa. The masculine includes the feminine and neuter genders.

5. The terms "person" or "persons" means natural persons, firms, partnerships, associations, corporations, subsidiaries, divisions, departments, joint ventures,

proprietorships, syndicates, or other legal, business or government entities, and all subsidiaries, affiliates, divisions, departments, branches, and other units thereof.

6. The terms "referring" or "relating," with respect to any given subject, means anything that constitutes, contains, embodies, reflects, identifies, states, refers to, deals with, or is in any manner whatsoever pertinent to that subject.

Coleman, Claire

From: Wilson,Elizabeth A. [Elizabeth.Wilson@cna.com]
Sent: Friday, June 12, 2009 11:30 PM
To: Calamaro, Raymond S.; Coleman, Claire
Cc: Davis,Heather E.
Subject: RE: Oversight Investigation - Document and Information Follow-up
Attachments: DBA PL 0309 v2.xls

Response to the first Bullet point: DAB PL 0309v2.xls
Response to the second bullet point: Experts for PTSD cases in litigation are selected by the attorney handling the case. Typically they use vendors in the geographic location of the claimant if it is feasible.
Response to the third bullet point: Correct with respect to all four sub-questions, we do not track this information and would have to manually review each claim file to obtain the information.

Elizabeth Wilson
SVP & Deputy General Counsel
312/822-4147 Telephone
312/817-3194 facsimile

From: Coleman, Claire [mailto:Claire.Coleman@mail.house.gov]
Sent: Friday, June 12, 2009 3:43 PM
To: Calamaro, Raymond S.
Cc: Wilson,Elizabeth A.; Davis,Heather E.
Subject: FW: Oversight Investigation - Document and Information Follow-up
Importance: High

Ray, these questions/information requests below have not yet been answered by CNA. I'd appreciate your assistance in getting these questions resolved as quickly as possible.

Thanks,
Claire

Claire E. Coleman
Counsel, Domestic Policy Subcommittee
Oversight and Government Reform Committee
B-349B Rayburn
Washington, DC 20515
202-225-6427 (main number)
202-225-2392 (fax)
claire.coleman@mail.house.gov

From: Coleman, Claire
Sent: Tuesday, June 09, 2009 1:30 PM
To: Coleman, Claire; 'Stuntz, Reid P. F.'; 'Wilson,Elizabeth A.'; 'heather.davis@cna.com'
Subject: Oversight Investigation - Document and Information Follow-up

All,

A few follow-up questions on your previous document production and our phone conversation on the production:

- In response to #5), you provided hard numbers for earned premiums but the rest of the numbers are percentages. Can we get corresponding hard numbers for the underwriting profit/loss calculations (which would enable us to calculate the underwriting gain/loss percentage). We need to understand the numbers behind the percentages.
- From our phone conversation last week, you were going to follow-up on how medical and psychological experts are chosen to represent you when cases are litigated before an ALJ.
- Just to confirm, my understanding from our conversation is that CNA does not track aggregate data on: 1) claim outcomes (whether are controverted, granted or denied); 2) number of cases that have informal dispute resolution with DOL; 3) number of cases that are adjudicated by an ALJ; or 4) the outcomes of cases litigated before an ALJ or appeals process. In order to obtain this information CNA would have to go to each individual claim file.

Thanks for clarification and further information,

Claire

Claire E. Coleman
Counsel, Domestic Policy Subcommittee

Oversight and Government Reform Committee
B-349B Rayburn
Washington, DC 20515
202-225-6427 (main number)
202-225-2392 (fax)
claire.coleman@mail.house.gov

From: Coleman, Claire
Sent: Thursday, June 04, 2009 4:54 PM
To: Stuntz, Reid P. F.; Wilson,Elizabeth A.; heather.davis@cna.com
Subject: Oversight Investigation - 2nd Request for Docs

Reid, Elizabeth, Heather,

Please see attached request for information of individual claimant files.

Thanks very much,

Claire

Claire E. Coleman
Counsel, Domestic Policy Subcommittee
Oversight and Government Reform Committee
B-349B Rayburn
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claire.coleman@mail.house.gov

Defense Base Act

Evaluated on an Accident Year basis -- as of March, 2009

	Actual	Actual	Actual	Actual	Actual	Actual	Actual	TOTAL	Projection
	AY 2002	AY 2003	AY 2004	AY 2005	AY 2006	AY 2007	AY 2008	AY 2002 - AY 2008	AY 2009
Financials (03/09)									
Earned Premium (000's)	6,521	18,867	54,659	62,065	80,550	95,442	98,164	416,269	98,000
Net Ultimate Loss & ALAE	36.7%	33.4%	39.3%	44.8%	60.3%	62.3%	61.5%	54.4%	62.8%
ULAE	3.7%	3.3%	3.9%	4.5%	6.0%	6.2%	6.1%	5.4%	6.3%
Underwriting Expense	15.3%	10.6%	6.4%	6.4%	5.6%	5.2%	5.1%	6.0%	5.1%
Agent Commissions	15.0%	15.0%	15.0%	15.0%	14.5%	14.0%	13.7%	14.3%	13.6%
Taxes (DOL)	3.4%	3.0%	4.7%	5.2%	5.7%	6.5%	6.3%	5.7%	6.5%
Subtotal (Expenses excluding ULAE)	33.7%	28.6%	26.1%	26.7%	25.8%	25.8%	25.0%	26.0%	25.2%
Projected Combined Ratio	**74.1%**	**65.4%**	**69.3%**	**75.9%**	**92.1%**	**94.3%**	**92.6%**	**85.8%**	**94.3%**
Underwriting Gain/(Loss)	**26%**	**35%**	**31%**	**24%**	**8%**	**6%**	**7%**	**14%**	**6%**

Dollar Version (000's)	Actual	Actual	Actual	Actual	Actual	Actual	Actual	TOTAL	Projection
	AY 2002	AY 2003	AY 2004	AY 2005	AY 2006	AY 2007	AY 2008	AY 2002 - AY 2008	AY 2009
Financials (03/09)									
Earned Premium (000's)	6,521	18,867	54,659	62,065	80,550	95,442	98,164	416,269	98,000
Net Ultimate Loss & ALAE	2,396	6,300	21,499	27,795	48,578	59,484	60,333	226,386	61,558
ULAE	240	630	2,150	2,780	4,858	5,948	6,033	22,639	6,156
Underwriting Expense	1,000	2,000	3,500	4,000	4,500	5,000	5,000	25,000	5,000
Agent Commissions	978	2,830	8,199	9,309	11,648	13,354	13,409	59,727	13,328
Taxes (DOL)	220	573	2,546	3,247	4,594	6,249	6,162	23,591	6,370
Subtotal (Expenses excluding ULAE)	2,198	5,403	14,245	16,556	20,742	24,603	24,571	108,318	24,698
Projected Combined Ratio	**74.1%**	**65.4%**	**69.3%**	**75.9%**	**92.1%**	**94.3%**	**92.6%**	**85.8%**	**94.3%**
Underwriting Gain/(Loss)	**1,687**	**6,534**	**16,765**	**14,935**	**6,372**	**5,407**	**7,227**	**58,926**	**5,589**

Notes:
AY is Accident Year (year that the loss occurred)
Assuming all War Hazard losses will be recovered from DOL.
Net Ultimate Loss & ALAE is after expected War Hazard recoveries.
ULAE is 10% of Est Net LR (Which is consistent with the financials).
ULAE is CNA's expense for our claims organization.
Underwriting Expense are based upon dollar inputs from Finance associated to overhead for DBA
Taxes are 15% of indemnity (45%) of Est Gross LR (before War Hazard Recovery)

Coleman, Claire

From: Wilson,Elizabeth A. [Elizabeth.Wilson@cna.com]
Sent: Monday, June 15, 2009 7:56 PM
To: Coleman, Claire
Cc: Calamaro, Raymond S.; Ware,Bryan
Subject: Information requested in 6/15 conference call
Attachments: At Large.xls

Attached is the information you requested in today's conference call with respect to the non-program business only.

<<At Large.xls>>

Elizabeth Wilson
SVP & Deputy General Counsel
312/822-4147 Telephone
312/817-3194 facsimile

DBA

Evaluated on an Accident Year basis -- as of May 2009

Standard Lines Pricing's Evaluation
All Dollar Figures are in Thousands

Percentages	Actual AY 2002	Actual AY 2003	Actual AY 2004	Actual AY 2005	Actual AY 2006	Actual AY 2007	Actual AY 2008	Total AY 2002 - AY 2008
Earned Premium (000's)	1,530	9,988	32,975	29,581	18,372	14,335	14,328	121,110
Ultimate Loss & ALAE (net of Recoveries)	11.2%	7.9%	27.8%	18.3%	20.5%	24.0%	39.4%	23.4%
ULAE	1.1%	0.8%	2.8%	1.8%	2.1%	2.4%	3.9%	2.3%
Underwriting Expense	15.3%	10.6%	6.4%	6.4%	5.6%	5.2%	5.1%	6.5%
Agents Commission	15.0%	15.0%	15.0%	15.0%	15.0%	15.0%	15.0%	15.0%
Taxes (DOL)	0.8%	1.3%	4.2%	2.0%	2.6%	2.0%	3.3%	2.8%
Subtotal (Expenses excluding ULAE)	31.1%	26.9%	25.6%	23.5%	23.1%	22.3%	23.4%	24.2%
Projected Combined Ratio	**43.4%**	**35.5%**	**56.1%**	**43.6%**	**45.7%**	**48.7%**	**66.8%**	**50.0%**
Underwriting Gain/(Loss)	**57%**	**65%**	**44%**	**56%**	**54%**	**51%**	**33%**	**50%**
Underwriting Gain/(Loss) - (000s)	**865**	**6,443**	**14,462**	**16,677**	**9,972**	**7,361**	**4,763**	**60,543**

Dollars	Actual AY 2002	Actual AY 2003	Actual AY 2004	Actual AY 2005	Actual AY 2006	Actual AY 2007	Actual AY 2008	Total AY 2002 - AY 2008
Earned Premium (000's)	1,530	9,988	32,975	29,581	18,372	14,335	14,328	121,110
Ultimate Loss & ALAE (net of Recoveries)	172	785	9,164	5,417	3,772	3,440	5,645	28,395
ULAE	17	78	916	542	377	344	565	2,839
Underwriting Expense	235	1,059	2,111	1,906	1,026	751	730	7,819
Agents Commission	229	1,498	4,946	4,437	2,756	2,150	2,149	18,166
Taxes (DOL)	12	125	1,374	602	469	290	476	3,347
Subtotal (Expenses excluding ULAE)	476	2,682	8,432	6,946	4,251	3,191	3,355	29,332
Projected Combined Ratio	**43.4%**	**35.5%**	**56.1%**	**43.6%**	**45.7%**	**48.7%**	**66.8%**	**50.0%**
Underwriting Gain/(Loss)	**57%**	**65%**	**44%**	**56%**	**54%**	**51%**	**33%**	**50%**
Underwriting Gain/(Loss) - (000s)	**865**	**6,443**	**14,462**	**16,677**	**9,972**	**7,361**	**4,763**	**60,543**

Notes:
AY is Accident Year (year that the loss occurred)
Assuming all War Hazard losses will be recovered from DOL
Ultimate Loss & ALAE (net of Recoveries) is after War Hazard recoveries
ULAE is 10% of Est Net LR (Which is consistent with the financials)
ULAE is CNA's expense for our claims organization
Underwriting Expense are based on dollar input from Finance associated to the overhead for DBA
Taxes are 15% of indemnity (45%) of Est Gross LR

CNA

333 S. Wabash Ave. Chicago IL 60604

August 5, 2009

The Hon. Dennis J. Kucinich
Chairman, Domestic Policy Subcommittee
House Committee on Oversight and Government Reform
2157 Rayburn House Office Building
Washington, D.C. 20515-6143

Re: Responses of CNA to Chairman Kucinich's July 14, 2009 Letter Requesting Answers to Certain Questions

Dear Chairman Kucinich:

In response to your July 14, 2009 letter to Chairman and CEO Thomas Motamed and General George Fay requesting answers to certain questions, attached please find CNA's initial responses. Please note that we have provided responses to each question and anticipate supplementing questions numbered 2, 4, 11, 12 and 14. We expect to provide you with the additional responses to those questions before Labor Day, pending the completion of a manual claim file review.

Respectfully Submitted,

Elizabeth Wilson

cc: The Hon. Jim Jordan
Ranking Minority Member

333 S. Wabash Ave. Chicago IL 60604

Responses of CNA to Chairman Kucinich's
July 14, 2009 Letter Requesting Answers to Certain Questions

1) A recent Department of Defense Inspector General audit found that military hospitals were not billing and collecting payment from contractors or their insurance providers for health care provided to their employees, and as a result these military treatment facilities have been burdened by the costs of providing free medical care to civilian contractors. What steps has CNA taken to make sure that military facilities are reimbursed for the care provided by military hospitals to civilian contractors?

Upon receiving notice of a claim where a military treatment facility is utilized, we make contact with the facility and provide our claim information and request medical and billing records. If we do not receive the information we continue to follow up even after the claimant has left the facility. If records are received we review and pay all appropriate amounts. In circumstances when we first learn that a military hospital has been utilized subsequent to the claimant's leaving the facility, we request medical and billing information.

Once an injured employee returns to the U.S., if he/she chooses to seek treatment at a Veterans Administration (VA) hospital, we often experience difficulty in obtaining medical or billing information. In instances where a claimant seeks medical treatment from a VA facility, we advise the claimant to give the CNA claim information to the facility. Additionally, we will also contact the facility and provide our information. In spite of these efforts, we have experienced difficulty in obtaining medical and billing information.

It is our claim philosophy and practice to pay what we owe and to treat claimants and providers fairly and with respect.

2) For the period 2002 to the present, how many claims has CNA denied in which CNA's own medical expert has sided with the claimant? What is CNA's policy with respect to fighting claims in which its doctors agree with the claimant's doctors regarding injury and disability?

We cannot recall any such situation. We do not have any systematic way to track situations in which CNA has challenged a claim when CNA's own medical expert has sided with the claimant. We certainly do not have any policy of fighting claims where CNA's medical experts agree in all respects with the claimant's doctors regarding compensable injury and disability.

3) What actions does CNA take to determine the qualifications of experts CNA uses to evaluate and contest PTSD claims?

We look for medical experts who specialize in the identified area of medicine such as PTSD and consider factors such as whether they have documented experience in treating military exposures and whether they have been published in this area of medicine. For example, one of the physicians we retained has been designated a "Diplomate in Clinical Psychology" by the American Board of Professional Psychology and has written extensively on psychiatric-related

disabilities. We rely upon our nursing staff, claim professionals and defense counsel in making these selections.

4) For the period 2002 to the present, what percentage of claims for treatment and benefits related to PTSD has CNA paid-in-full, paid in part, and denied outright?

CNA will be able to respond to this question after our more in-depth file review.

5) For the period 2002 to the present, what percentage of claims that CNA has submitted to the Department of Labor (DOL) for reimbursement under the War Hazards Act have been granted by DOL? What is the total dollar amount of claims submitted to DOL for reimbursement under the War Hazards Act? What is the total dollar amount that CNA has been reimbursed from DOL for War Hazards Act claims?

CNA has received approval from the DOL for War Hazard reimbursement on approximately 65% of all claims submitted for reimbursement under the War Hazards Act. CNA strives to make timely claim determinations regardless of whether the claim may eventually be subject to reimbursement under the War Hazards Act. At the time a claim is received by CNA, it is often unclear whether the claim will or will not be subject to reimbursement, as that evaluation is often done after the claim is closed and all providers have been paid. Of the $165M in claim payments (and another $156M in case reserves) made by CNA since 2002, CNA has only submitted approximately $11.4M to the DOL for reimbursements under the DBA. CNA has been reimbursed approximately $4.6M of that amount. CNA has received approximately $600K in additional expense reimbursement.

6) For the period 2002 to the present, what percentage of claims has CNA sought an Administrative Law Judge (ALJ) ruling to determine whether a claim falls under the War Hazards Act? Does CNA believe it needs a ruling by an ALJ stating that a claim falls under the War Hazards Act in order to apply for reimbursement from DOL?

CNA has not sought an Administrative Law Judge (ALJ) ruling to determine whether a claim falls under the War Hazards Act. The statutes/regulations/rules do not require nor do we seek an ALJ ruling stating that a claim falls under the War Hazards Act in order to apply for reimbursement from DOL. The statutes set forth the qualifications for reimbursement and when, in our opinion, a claim qualifies, we submit a request for reimbursement pursuant to the directions provided in statute/regulations/rules. The Division of Federal Employment Compensation (DFEC) has authority to determine which covered claims fall under the definition of what is covered by the War Hazard Compensation Act (WHCA).

7) Does CNA notify the Department of Defense or Department of Labor when a contract firm cancels a Defense Base Act workers' compensation insurance policy?

When a contract firm cancels a non-program DBA policy, we notify the DOL, the agent of record and the insured. If the policyholder is part of a DBA program, we notify the program contract officer.

8) What steps has CNA taken to make sure that the foreign subcontractors it insures report worker injuries? What steps has CNA taken to educate foreign nationals working for contractors or subcontractors on their rights to benefits under the DBA?

Neither CNA nor any other carrier has control over whether or not its insureds report injuries. We certainly expect that injuries are reported and the insurance policy states that

injuries/claims are to be reported and provides guidance on how to report claims.

Non-program business is submitted to CNA via agent or broker (producer). The CNA application for (non-program) DBA insurance has a question asking whether the contractor is the prime contractor or one of the subcontractors for the job. If the insured is the prime contractor, we ask the producer bringing us the account to find out if there are any subcontractors on the job. If subcontractors do exist, we are advised of their names and responsibilities. The subcontractor is then included as an insured on the prime contractor's policy. During our discussions with the producer we educate them about DBA coverage benefits and the claim process. It is the duty and responsibility of the producer bringing us the account to educate the insured about DBA coverage, claims handling and benefits. We as a carrier do not routinely have direct access to the contractors and would have contact with their employees only when the employee submits a claim.

The application for program DBA business states that all contractors, primary contractors and subcontractors, have to individually purchase their own DBA insurance. Thomas Rutherfoord, Inc. is an insurance agency that acts as a managing general underwriter for CNA's program DBA accounts. When Rutherfoord receives these applications they spend time with the insureds educating them about DBA benefits and the claim procedures. In fact, Rutherfoord spends quite a bit of their time on this education process for prime contractors and subcontractors.

Additionally, at the time a policy is bound each known insured, including subcontractors, receive a "Claim Kit." If CNA is subsequently made aware of a subcontractor, the subcontractor also receives a Claim Kit. Within the Claim Kit are instructions on how to file a claim including contact information and LS 202 claim reporting forms in eight different languages.

Upon receiving a new claim our claim handlers are required to make contact with the insured and injured worker. Upon making contact, our claim handlers explain to both parties the claim process. In addition, upon receipt of an LS 202 claim reporting form a copy of the LS 202 is provided to the DOL. The DOL sets up its own internal file and sends contact information to the injured worker. Included in the DOL material is contact information for the DOL, in the event that the injured worker has any questions or concerns. The only exception is in regard to injured workers who reside in Iraq or Afghanistan. In these two countries, telephonic contact is not possible in the large majority of instances. In addition, contact via mail can be dangerous to the claimant due to the fact that it is looked on negatively within their country that they are employed by a contractor who in many cases is based in the USA. In these instances, we attempt to make contact with them via the internet as well as through our vendors located within Iraq and Afghanistan.

Prior to 2005, we conducted educational seminars in conjunction with the DOL to assist contractors who have direct contact with subcontractors that they hire. These seminars were open to the other carriers, insureds and producers. Subsequently there were not enough interested external parties that wanted to attend this type of seminar. The DOL was continuing to sponsor seminars in DC so the need for a CNA sponsored seminar dwindled.

9) General Fay testified that with the 5500 or so claims filed with CNA in the past seven years, CNA "believes that we have only gone to an administrative ruling in fewer than 20 cases." During the subcommittee's investigation, CNA's Deputy General Counsel represented to subcommittee staff that it does not routinely track data on how many claims are disputed; how many go through dispute resolution process with DOL; or how many are adjudicated by an ALJ. (See attached email). Where

and how did you obtain this data provided in your testimony? Did CNA manually review the files?

From the inception of the program we have used only one panel law firm and one staff counsel operation to handle our DBA claims when needed. These files represent a small subset of the approximately 6600 total DBA claims. (The 6600 claims are made up of approximately 5900 claims from 2002 through the end of 2008, and include about 400 more claims than were known at the time of the testimony. Over 700 claims are from the 2009 policy year, which was not previously requested.) At our request, the law firm and staff counsel manually reviewed their past and current pending files to determine which claims had been taken to hearing before the ALJ and the ultimate outcome. This data were used to support our testimony. As explained in previous responses, if we do not have a business reason for "tracking" certain data elements we do not, which is not the same as stating we do not have the data. For purposes of clarification, there was not sufficient time for us at CNA to review all of our files manually, but because we only used two sets of lawyers we were able to have them manually check the limited number of matters they handled on our behalf.

10) CNA has emphasized throughout this Subcommittee's investigation that it has a very small percentage of market share for the "non-program" DBA business. Why doesn't CNA have more market share? Has CNA attempted to capture more of the "nonprogram" DBA business?

CNA has made a conscious effort not to pursue a larger market share of non-program business. We are very selective about the exposures we underwrite. Our non-program underwriting preference is to write lower risk, smaller businesses. This approach to non-program DBA underwriting fits well with the books of business of our producers. We rely on our existing producer base which, when the need arises, knows we can provide DBA coverage to round out existing coverage placed with CNA. It is also our understanding that many of the larger non-program accounts have pre-existing relationships with other carriers and they tend to stay with that carrier when rounding out or satisfying additional coverage needs.

11) For the period 2002 to the present, how much does CNA spend per year litigating disputed DBA workers' compensation claims?

We do not have a method to easily track how much we spend each year litigating DBA cases. Our best proxy is to track legal fees spent over this time, although many times we hire counsel for reasons other than contesting claims. To the extent we can identify non-litigation legal fees we have excluded them from the number below. For example, sometimes we hire counsel simply to analyze a discrete legal issue or to advise us on whether a particular claim is or is not compensable under the law. In any event, we believe that the total amount of legal fees paid on claims arising under the DBA program (both non-program and program) since 2002 is only about $3.6M, that is, only about 0.8% of the premium we earned over that period of time.

12) For the period 2002 to the present, how many claims of which CNA originally denied has CNA been ordered by an ALJ to provide compensation to the claimant? What is the total dollar amount CNA has paid to claimants as a result of ALJ rulings?

There are six cases in which CNA lost all issue(s) brought before the ALJ. For those six, CNA's total expected losses are $3.0 million. This amount includes payments and reserves on issues that were not disputed, as well as the disputed issues.

In three other cases CNA lost at least one issue brought before the ALJ, but also won at least one issue. On these three cases CNA's total expected losses are $0.5 million. This amount includes payments and reserves on issues that were not disputed, as well as the disputed

issues.

13) Please provide a detailed explanation of the status of indemnity payments being made to Mr. Timothy Newman and the basis for which CNA is disputing its past and future weekly indemnity payments to Mr. Newman.

We have paid indemnity benefits to Mr. Newman as follows:

- Temporary Total Disability (9/3/05-10/10/08) at the rate of $1,008 per week for a total of $162,288; and
- Temporary Partial Disability (10/11/08-01/30/09) at the rate of $781.81 per week as he was capable of light duty.

Mr. Newman accepted a position on 09/10/06 with his employer in a capacity different from that of his prior employment at a reduced wage. At that time we should have reduced his disability rate to account for the reduced wages he was now receiving from his employer, however, in error we continued to pay at the maximum rate resulting in an overpayment during the period of 09/10/06 – 10/10/08.

Mr. Newman voluntarily quit his employment shortly after for personal (non-medical) reasons. At that time, he was capable of earning wages and hence not permanently totally disabled, so CNA continued his benefits at the TPD rate.

The change to TPD at the lower rate was challenged by Mr. Newman and a court date was requested. In the interim CNA in good faith voluntarily agreed to pay Mr. Newman again at the maximum rate beginning 01/31/09 while we tried to work towards resolution by way of stipulation or ALJ decision. We are currently continuing his TTD benefits at the maximum rate of $1,047.16 based on a revised wage statement until this issue is resolved. We have a hearing scheduled on 8/27/09 regarding the issue of retained wage earning capacity.

14) DOL has testified that it holds informal hearings to try to resolve disputes between carrier and contractor, and provide recommendations, sometimes urging the carrier to pay the claimant.

a. Have your claims adjusters ever ignored recommendations made by a DOL Administrator during these informal resolution proceedings?

Our claims adjusters do not ignore recommendations made by the DOL administrator during informal resolution proceedings. We are within the legal requirements to legitimately disagree. We participate fully in the proceedings and fairly take into account all recommendations, facts and evidence presented. We do not know how often we agree or disagree with the DOL's recommendation to resolve a dispute. However, since we have had so few claims actually proceed to an ALJ determination, it stands to reason that there would be very few occasions if any where there is an issue with the DOL recommendation. We have never been found by the DOL to ignore recommendations nor reprimanded for such.

b. On how many occasions?

As stated above, we do not ignore DOL administrator recommendations.

c. Who makes the determination to ignore a recommendation made by DOL? Is this company policy?

Recommendations from the DOL following an informal hearing are not ignored. The results of the informal hearing are discussed in detail with defense counsel and in some instances DBA Claim Management. If the recommendation is not supported by the investigation or the medical evidence, the decision is made to disagree and this difference of opinion is conveyed to the injured worker's counsel.

There is no company policy to ignore or not comply with a DOL recommendation following an informal hearing. Each case is determined on its own merits.

15) What is the single most important reform that you believe is needed to improve your companies' ability to provide fair and comprehensive benefits to your claimants?

CNA believes two reforms are most important for improving its ability to provide fair and comprehensive benefits to our claimants. First, the 14-day rule should be refined and in some instances extended to allow for a more detailed analysis and review of claims. It is important to CNA to be able to process all claims fairly, which is especially difficult in the case of DBA claims when they are received from remote areas in war zones where communications are difficult. Unfortunately, the result is that insurance carriers are often forced to file LS-207 forms initially denying a portion of the claim or the entire claim to avoid penalties or simply to buy more time, a necessary action that is often—and understandably—misinterpreted. A regulatory scheme that creates such incentives can only produce unintended, and sometimes, tragic results.

The Department of Labor requires that payments be made to claimants within 10 days, even if these payments are being made to individuals overseas. This requirement is extremely difficult to satisfy because payments to DBA claimants are typically sent using wire transfers. This 10-day time requirement should also be adjusted to reflect the realities of the present.

Second, CNA believes that DOD should adopt a modified request-for-proposal-awarded program method, like the one used by the State Department, USAID, and the Army Corps of Engineers, to cover all of their civilian contractors. An RFP-awarded program could be established for each of the divisions of the military within DOD. If the Army, Navy, Air Force, Marines, Merchant Marine and other affiliated, but independent, branches were to each have their own DBA programs, the insurance market might respond favorably to the respective requests for proposals. Each division could possibly also further subdivide into smaller groups to create their own competitively-bid programs as well. The objective would be to have small enough groups to be relatively homogeneous and supportable by a single insurer, yet large enough to diversify the volatility of the risks. These fixed rate programs would also simplify the bidding (RFP) process for the contractors.

CNA

333 S. Wabash Ave. Chicago IL 60604

September 16, 2009

The Hon. Dennis J. Kucinich
Chairman, Domestic Policy Subcommittee
House Committee on Oversight and Government Reform
2157 Rayburn House Office Building
Washington, D.C. 20515-6143

Re: September 16, 2009 Supplemental Responses of CNA to Chairman Kucinich's July 14, 2009 Letter Requesting Answers to Certain Questions

Dear Chairman Kucinich:

In response to your July 14, 2009 letter to Chairman and CEO Thomas Motamed and General George Fay requesting answers to certain questions, attached please find CNA's supplemental responses.

Respectfully Submitted,

Elizabeth Wilson

Elizabeth Wilson

cc: The Hon. Jim Jordan
Ranking Minority Member

333 S. Wabash Ave. Chicago IL 60604

Supplemental Responses Dated September 16, 2009 of CNA to Chairman Kucinich's July 14, 2009 Letter Requesting Answers to Certain Questions

2) For the period 2002 to the present, how many claims has CNA denied in which CNA's own medical expert has sided with the claimant? What is CNA's policy with respect to fighting claims in which its doctors agree with the claimant's doctors regarding injury and disability?

As previously stated, CNA does not normally track such information. However, after manually reviewing the approximately 4,830 Defense Base Act (DBA) claim files that fell within the requested time period, we found only one (1) instance where we determined a claim was not compensable even though CNA's own medical expert agreed with the claimant's physician. In that case, CNA's denial of compensability was based not on a disagreement as to *whether* there was an injury, but rather on *how* that injury occurred (*i.e.*, the factual investigation revealed the injury did not occur in a manner that would fall within the coverage). That claim currently remains open and in dispute.

We also reiterate, though, that CNA does not have a policy of fighting claims in which our own doctor agrees with the claimant's doctor regarding injury or disability. It is important to understand that compensability decisions are driven by two key factors – the medical evidence and the results of the specific factual investigation.

4) For the period 2002 to the present, what percentage of claims for treatment and benefits related to PTSD has CNA paid-in-full, paid in part, and denied outright?

We do not regularly track situations where a claimant includes a claim for treatment and benefits related to PTSD. Consequently, in order to answer this question, we looked for related information as part of the manual file review. On this question, the review revealed that there was only a small portion of claims where a claimant even sought PTSD benefits. Indeed, there were only 197 such PTSD occurrences identified, less than 5% of the total claims submitted to CNA over this period. Of those 197 occurrences, 117 (59% of the 197 total) were paid in full with no challenges, another 20 (10%) were paid in part and 23 (12%) were initially denied pending the receipt of sufficient information on which to base a decision. The 23 denied pending sufficient information are cases in which we were required by the current LS207 rules to pay or deny within a specified timeframe. We cannot make an appropriate decision without adequate information therefore we filed the LS207 denying the claim pending receipt of additional information. There were only 37 (19%) occurrences where we denied a PTSD claim based on actual disputes and it appears that all but a few are not being contested by the claimants. One of these occurrences was a single case where 21 claimants filed for PTSD.

11) For the period 2002 to the present, how much does CNA spend per year litigating disputed DBA workers' compensation claims?

Our file review did not yield any information that would enable us to supplement our original response to this question.

12) For the period 2002 to the present, how many claims of which CNA originally denied has CNA been ordered by an ALJ to provide compensation to the claimant? What is the total dollar amount CNA has paid to claimants as a result of ALJ rulings?

After completing the manual file review, we can confirm the nine (9) occurrences we mentioned in our original response. The file review also revealed one (1) additional occurrence in which CNA denied all or a portion of a claim and an ALJ subsequently opined that some compensation should be paid.

Notably, the disputes in these occurrences were not necessarily based on the compensability of the claims. In some instances the litigated disputes centered on one or two aspects of the claims, such as average weekly wage, dependency or medical necessity. It is also important to note that in some instances the ALJ agreed with some portion of CNA's position. The total amount expected to be paid out on all ten occurrences is approximately $5.3M which includes payments on disputed issues as well as aspects of the claims never in dispute. Of the $5.3 million, $3.5 million is already paid to date.

14) DOL has testified that it holds informal hearings to try to resolve disputes between carrier and contractor, and provide recommendations, sometimes urging the carrier to pay the claimant.

a. Have your claims adjusters ever ignored recommendations made by a DOL Administrator during these informal resolution proceedings?

We reiterate that our claims adjusters do not ignore recommendations made by the DOL administrator. In fact, CNA gives them thoughtful and serious consideration. That said, when warranted, we are well within the legal requirements to legitimately disagree. Regardless of our position in any given case, however, we participate fully in the proceedings and fairly take into account all recommendations, facts and evidence presented. And, as mentioned, we have never been found by the DOL to ignore recommendations nor reprimanded for such.

b. On how many occasions?

As stated, we do not ignore ALJ recommendations. Further, as part of the manual file review, we identified 81 cases that proceeded to a stage where an ALJ provided recommendations. In almost 80 percent of those cases, we followed the recommendations. In the remaining 17 instances, after considering the DOL recommendation and reviewing the case, we did not believe the evidence warranted proceeding (and therefore we did not proceed) as recommended by the ALJ. However, only two (2) of the 17 instances where CNA disagreed with the DOL administrator proceeded to an ALJ ruling. Of these two cases, one was decided in favor of CNA's position on all issues. The other was decided in the claimant's favor on all issues.

c. Who makes the determination to ignore a recommendation made by DOL? Is this company policy?

We have no further information to supplement our original response.

ONE HUNDRED ELEVENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM
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July 14, 2009

Mr. Edward M. Liddy
Chairman and Chief Executive Officer
American International Group, Inc.
70 Pine Street
New York, New York 10270

Mr. Kris Moor
President, AIU Holdings, Inc.
30th Floor
175 Water Street
New York, New York 10005

Mr. Charles Schader
Senior Vice President and Chief Claims Officer
American International Group, Inc.
70 Pine Street
New York, New York 10270

Dear Messrs. Liddy, Moor and Schader:

In connection with the Domestic Policy Subcommittee of the Oversight and Government Reform Committee's hearing on June 18, 2009, "After Injury, the Battle Begins: Evaluating Workers' Compensation for Civilian Contractors in War Zones," the Subcommittee submits the following questions for the hearing record:

1) A recent Department of Defense Inspector General audit found that military hospitals were not billing and collecting payment from contractors or their insurance providers for health care provided to their employees, and as a result these military treatment facilities have been burdened by the costs of providing free medical care to civilian contractors.[1] What steps has

[1] Army Audit Agency, *Audit of Defense Base Act Insurance for the Logistics Civil Augmentation Program, Audit of Logistics Civil Augmentation Program Operations in Support of Operation*

AIG taken to make sure that military facilities are reimbursed for the care provided by military hospitals to civilian contractors?

2) For the following requests, if complete data analyzing all claims processed by AIG is unavailable, please analyze a representative sample of claims from 2002 to the present that would produce statistically valid data. Please include a statement from the person(s) involved in selecting the sample used to explain the methodology used, including but not limited to the total lot size, the type of sample chosen, and methods employed to ensure that data used were randomly selected.

    a. For the period 2002 to the present, how many claims has AIG denied in which AIG's own medical expert has sided with the claimant? What is AIG's policy with respect to fighting claims in which its doctors agree with the claimant's doctors regarding injury and disability?

    b. For the period 2002 to the present, what percentage of claims for treatment and benefits related to PTSD has AIG paid-in-full, paid in part, and denied outright?

    c. For the period 2002 to the present, what percentage of claims has AIG sought an Administrative Law Judge (ALJ) ruling to determine whether a claim falls under the War Hazards Act? Does AIG believe it needs a ruling by an ALJ stating that a claim falls under the War Hazards Act in order to apply for reimbursement from DOL?

    d. For the period 2002 to the present, how many claims of which AIG originally denied has AIG been ordered by an ALJ to provide compensation to the claimant? What is the total dollar amount AIG has paid to claimants as a result of ALJ rulings?

    e. For the period 2002 to the present, what percentage of claims that AIG has submitted to the Department of Labor (DOL) for reimbursement under the War Hazards Act have been granted by DOL? What is the total dollar amount of claims submitted to DOL for reimbursement under the War Hazards Act? What is the total dollar amount that AIG has been reimbursed from DOL for War Hazards Act claims?

3) For the period 2002 to the present, how much does AIG spend per year litigating disputed DBA workers' compensation claims?

4) What actions does AIG take to determine the qualifications of experts AIG uses to evaluate and contest PTSD claims? With reference to Mr. Schader's testimony that Dr. Griffith is a qualified expert, please provide documentation supporting this claim, and explain how AIG justifies continued use of an expert who has admitted he is not an expert on PTSD, nor on the

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Iraqi Freedom (Sept. 28, 2007) (A-2007-0204-ALL), available at http://s3.amazonaws.com/propublica/assets/contractors/dodig_health_care_contractors_090504.pdf.

MMPI2, the test used in diagnosis and treatment of PTSD, and consistently denies insured's claims of PTSD.

5) Does AIG notify the Department of Defense or Department of Labor when a contract firm cancels a Defense Base Act workers' compensation insurance policy?

6) What steps has AIG taken to make sure that the foreign subcontractors it insures report worker injuries? What steps has AIG taken to educate foreign nationals working for contractors or subcontractors on their rights to benefits under the DBA?

7) AIG has defended its practice of calculating injured workers disability payments under a "blended rate" approach, whereby the insurer averages compensation earned overseas with compensation earned in stateside employment. This standard was recently rejected by the Benefits Review Board in *K.S. v. Brown & Root*, B.RB No. 08-0593 (March 13, 2009). Is AIG still using the blended rate approach when calculating indemnity payments for claimants? Does AIG still defend the blended rate approach in litigation as the most appropriate formula for calculating the average weekly wage?

8) On June 25, 2007 an AIG representative represented to the media that AIG pays more than 90% of its claims. AIG has since backtracked and now represents it pays "a vast majority of claims." Your staff was unable to give data quantifying what percentage of claims it has paid, because it represented that AIG has no system in place to collect data analyzing denials and litigation of claims. Instead, staff stated that the representation that AIG pays a vast majority of claims is based on observing "general trends."

    a. What was the basis for the statistic AIG provided about itself in 2007?

    b. Explain how you conduct oversight of the quality of your benefits services if you have no modern system to monitor whether the seventy-plus DBA claims processors are routinely granting or denying legitimate benefits?

9) At the hearing, Mr. John Woodson testified that he had not received money for eye glasses needed to see, and in response, Mr. Schader stated that AIG had in fact granted Mr. Woodson's request for glasses in April, 2009. If this is the case, why hasn't Mr. Woodson received the money to obtain new eye glasses? Please provide support for Mr. Schader's testimony that AIG has "done is everything we could have done" for Mr. John Woodson.

10) Please provide a detailed explanation about the status of Mr. Kevin Smith's claims for benefits to treat his PTSD and AIG's justification for failing to pay any medical expenses for PTSD treatment.

11) DOL testified that it holds informal hearings to try to resolve disputes between carrier and contractor, and provide recommendations, sometimes urging the carrier to pay the claimant.

    a. Has AIG's claims adjusters ever ignored recommendations made by a DOL administrator during these informal resolution proceedings?

b. On how many occasions?

c. What is the company policy with respect to making claims decisions contrary to the recommendations of DOL?

12) What is the single most important reform of the Defense Base Act that you believe is needed to improve your companies' ability to provide fair and comprehensive benefits to your claimants?

The Oversight and Government Reform Committee is the principal oversight committee in the House of Representatives and has broad oversight jurisdiction as set forth in House Rule X. An attachment to this letter provides information on how to respond to the Subcommittee's request.

We request that you provide these documents as soon as possible, but in no case later than **5:00 p.m. on Wednesday, August 5, 2009**.

If you have any questions regarding this request, please contact Claire Coleman, counsel, at (202) 225-6427.

Sincerely,

Dennis J. Kucinich

Dennis J. Kucinich
Chairman
Domestic Policy Subcommittee

cc: Jim Jordan
Ranking Minority Member

Domestic Policy Subcommittee Document Request Instruction Sheet

In responding to the document request from the Domestic Policy Subcommittee, Committee on Oversight and Government Reform, please apply the instructions and definitions set forth below.

Instructions

1. In complying with the request, you should produce all responsive documents in your possession, custody, or control.

2. Documents responsive to the request should not be destroyed, modified, removed, transferred, or otherwise made inaccessible to the Subcommittee.

3. In the event that any entity, organization, or individual denoted in the request has been, or is currently, known by any other name than that herein denoted, the request should be read also to include them under that alternative identification.

4. Each document produced should be produced in a form that renders the document capable of being copied.

5. When you produce documents, you should identify the paragraph or clause in the Subcommittee's request to which the documents respond.

6. Documents produced in response to this request should be produced together with copies of file labels, dividers, or identifying markers with which they were associated when this request was issued. To the extent that documents were not stored with file labels, dividers, or identifying markers, they should be organized into separate folders by subject matter prior to production.

7. Each folder and box should be numbered, and a description of the contents of each folder and box, including the paragraph or clause of the request to which the documents are responsive, should be provided in an accompanying index.

8. It is not a proper basis to refuse to produce a document that any other person or entity also possesses a nonidentical or identical copy of the same document.

9. If any of the requested information is available in machine-readable or electronic form (such as on a computer server, hard drive, CD, DVD, memory stick, or computer backup tape), you should consult with Subcommittee staff to determine the appropriate format in which to produce the information.

10. The Committee accepts electronic documents in lieu of paper productions. Documents produced in electronic format should be organized, identified, and indexed electronically in a manner comparable to the organizational structure called for in (6) and (7) above. Electronic document productions should be prepared according to the following standards:

    (a) The production should consist of single page TIF files accompanied by a Concordance-format load file, an Opticon reference file, and a file defining the fields and character lengths of the load file.

    (b) Document numbers in the load file should match document Bates numbers and TIF file names.

    (c) If the production is completed through a series of multiple partial productions, field names and file order in all load files should match.

11. In the event that a responsive document is withheld on any basis, you should provide the following information concerning the document: (a) the reason the document is not being produced; (b) the type of document; (c) the general subject matter; (d) the date, author, and addressee; and (e) the relationship of the author and addressee to each other.

12. If any document responsive to this request was, but no longer is, in your possession, custody, or control, you should identify the document (stating its date, author, subject and recipients) and explain the circumstances by which the document ceased to be in your possession, custody, or control.

13. If a date or other descriptive detail set forth in this request referring to a document is inaccurate, but the actual date or other descriptive detail is known to you or is otherwise apparent from the context of the request, you should produce all documents which would be responsive as if the date or other descriptive detail were correct.

14. This request is continuing in nature and applies to any newly discovered document. Any document not produced because it has not been located or discovered by the return date should be produced immediately upon location or discovery subsequent thereto.

15. All documents should be bates-stamped sequentially and produced sequentially. In the cover letter, you should include a total page count for the entire production, including both hard copy and electronic documents.

16. For paper productions, four sets of documents should be delivered: two sets to the majority staff and two sets to the minority staff. For electronic productions, one dataset to the majority staff and one dataset to minority staff are sufficient. Productions should be delivered to the majority staff in B-349B Rayburn House Office Building and the minority staff in B-350A Rayburn House Office Building. You should consult with Subcommittee staff regarding the method of delivery prior to sending any materials.

17. Upon completion of the document production, you should submit a written certification, signed by you or your counsel, stating that: (1) a diligent search has been completed of all documents in your possession, custody, or control which reasonably could contain responsive documents; and (2) all documents located during the search that are responsive have been produced to the Subcommittee or identified in a privilege log provided to the Subcommittee.

Definitions

1. The term "document" means any written, recorded, or graphic matter of any nature whatsoever, regardless of how recorded, and whether original or copy, including, but not limited to, the following: memoranda, reports, expense reports, books, manuals, instructions, financial reports, working papers, records notes, letters, notices, confirmations, telegrams, receipts, appraisals, pamphlets, magazines, newspapers, prospectuses, interoffice and intra-office communications, electronic mail (email), contracts, cables, notations of any type of conversation, telephone calls, meetings or other communications, bulletins, printed matter, computer printouts, teletypes, invoices, transcripts, diaries, analyses, returns, summaries, minutes, bills, accounts, estimates, projections, comparisons, messages, correspondence, press releases, circulars, financial statements, reviews, opinions, offers, studies and investigations, questionnaires and surveys, and work sheets (and all drafts, preliminary versions, alterations, modifications, revisions, changes, and amendments of any of the foregoing, as well as any attachments or appendices thereto). The term also means any graphic or oral records or representations of any kind (including without limitation, photographs, charts, graphs, voice mails, microfiche, microfilm, videotape, recordings and motion pictures), electronic and mechanical records or representations of any kind (including, without limitation, tapes, cassettes, disks, computer server files, computer hard drive files, CDs, DVDs, memory sticks, and recordings), and other written, printed, typed, or other graphic or recorded matter of any kind or nature, however produced or reproduced, and whether preserved in writing, film, tape, disk, videotape or otherwise. A document bearing any notation not a part of the original text is to be considered a separate document. A draft or non-identical copy is a separate document within the meaning of this term.

2. The term "documents in your possession, custody, or control" means (a) documents that are in your possession, custody, or control, whether held by you or your past or present agents, employees, or representatives acting on your behalf; (b) documents that you have a legal right to obtain, that you have a right to copy, or to which you have access; and (c) documents that you have placed in the temporary possession, custody, or control of any third party.

3. The term "communication" means each manner or means of disclosure or exchange of information, regardless of means utilized, whether oral, electronic, by document or otherwise, and whether face-to-face, in a meeting, by telephone, mail, telexes, discussions, releases, personal delivery, or otherwise.

4. The terms "and" and "or" shall be construed broadly and either conjunctively or disjunctively to bring within the scope of the request any information which might otherwise be construed to be outside its scope. The singular includes plural number, and vice versa. The masculine includes the feminine and neuter genders.

5. The terms "person" or "persons" means natural persons, firms, partnerships, associations, corporations, subsidiaries, divisions, departments, joint ventures,

proprietorships, syndicates, or other legal, business or government entities, and all subsidiaries, affiliates, divisions, departments, branches, and other units thereof.

6. The terms "referring" or "relating," with respect to any given subject, means anything that constitutes, contains, embodies, reflects, identifies, states, refers to, deals with, or is in any manner whatsoever pertinent to that subject.

PATTON BOGGS LLP
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August 5, 2009

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DELIVERY BY HAND AND EMAIL

The Honorable Dennis J. Kucinich
Chairman
Subcommittee on Domestic Policy
Committee on Oversight and Government Reform
B-349B Rayburn House Office Building
Washington, D.C. 20515

Re: July 14, 2009 Requests for Information to AIG, Inc.

Dear Chairman Kucinich:

On behalf of the American International Group, Inc., and its member companies ("AIG"), we are pleased to provide information and documents responsive to your letter requests of July 14, 2009.

In the first of the two letters, the Subcommittee posed additional questions about a variety of Defense Base Act ("DBA") issues for the hearing record. AIG's responses are contained below, and include documents marked AIG14478-AIG14502. As we have discussed with Claire Coleman and Jaron Bourke of your staff, AIG will produce additional responsive documents and information to the Subcommittee as expeditiously as possible, and anticipate completing production of all documents by August 7, 2009.

Based on a proposal made in writing to your staff, which we understand is an acceptable way to proceed, AIG will employ a sampling protocol in order to respond to Question 2. AIG has now begun the collection and sampling process for Question 2. AIG will produce documents, if any, related to 2(a), 2(b) and 2(d) when it produces the data sought in those parts of Question 2.

As with its previous productions to the Subcommittee, AIG wishes to designate these documents and information as containing confidential, proprietary and/or trade secret information. AIG respectfully asserts that the public disclosure of this information could materially injure AIG's business and operations, and consequently impede AIG's ability to repay the money it owes to American taxpayers.

PATTON BOGGS LLP
ATTORNEYS AT LAW

Responses to Additional Questions for the Hearing Record

Question 1: Upon receipt of an invoice for medical treatment in connection with a DBA claim, AIG reviews the invoice and pays it if appropriate. Unfortunately, U.S. military treatment facilities do not have the computer systems or logistical capability to provide AIG with invoices for the medical treatment provided to civilian contractors, and understandably AIG cannot pay invoices for medical treatment it never receives.[1]

To assist the U.S. military with this problem, AIG has offered on two separate occasions to work with the U.S. Department of Labor ("DOL") and the U.S. Department of Defense ("DOD"). Specifically, AIG offered to provide recommendations and subject matter experts to assist with software development and protocols that should address problems of the kind identified in this Question. To date, neither the DOL nor the DOD has accepted AIG's offer to provide this assistance.

Question 2: As requested, AIG previously submitted a protocol to the Subcommittee explaining the methodology by which it will respond to Question 2(a), (b) and (d) below. As noted above, we understand the proposed approach is acceptable to your staff. AIG will accordingly provide the statistical data sought by Questions 2(a), 2(b) and 2(d) as expeditiously as possible.

2(a): *Response pending completion of statistical sampling.*

2(b): *Response pending completion of statistical sampling.*

2(c): AIG has never sought an Administrative Law Judge ("ALJ") ruling to determine whether a claim falls under the War Hazards Compensation Act ("WHCA"). In fact, ALJs focus on issues surrounding the benefits a claimant is entitled to, and do not address the separate and distinct issue of whether a particular claim falls within the scope of the WHCA. Rather, it is the DOL's Division of Federal Employees' Compensation ("DFEC") that has the sole authority within the DOL to determine that issue.

2(d): *Response pending completion of statistical sampling.*

2(e): As of June 30, 2009, AIG has submitted 496 claims to DFEC for reimbursement under the WHCA. The reimbursement requested on these claims for payments made by AIG is approximately $50.4 million. Notably, AIG is entitled to additional

[1] The U.S. military has submitted some bills to AIG regarding treatment at Landsthul Medical Center in Germany, and in response to which AIG has made more than 90 payments totaling approximately $1.1 million to date.

reimbursement of approximately $7.5 million for administrative fees (15% of the $50.4 million figure).

To date, AIG has received either full or partial reimbursement on 81 of the 496 claims. As respects the amount paid by AIG, DFEC has reimbursed approximately $5.5 million of the $50.4 million requested. In addition, DFEC has reimbursed AIG approximately $676,000 for administrative fees of the $7.5 million to which AIG is entitled. To date, AIG has identified only three claims it submitted that have been determined by DFEC as not being entitled to reimbursement under WHCA.

Question 3: AIG does not track the amount of money it spends litigating disputed DBA workers' compensation claims separate from other types of expenses, and is thus unable to provide an accurate figure in response to this question. AIG routinely incurs myriad fees and costs in connection with DBA claims wholly unrelated to litigating disputed claims. For example, AIG incurs fees for arranging medical evacuations and other travel arrangements, such as for commercial air travel and accompanying medical attendants. It also incurs fees for on-the-ground investigators to locate witnesses, take their statements and arrange for delivery of benefits. Further, AIG incurs fees for nurse case managers, vocational rehabilitation services, collecting medical records, translating documents, getting an apostille to authenticate documents and retaining guardians for minors.

Question 4: AIG obtains medical professionals through a variety of sources, and evaluates the qualifications of those professionals on the basis of multiple criteria. Before AIG hires a professional in connection with a Post Traumatic Stress Disorder ("PTSD") claim, for example, it considers the candidate's educational background, clinical experience, and geographic location. AIG has previously recommended to the DOL that it enlist the resources of the U.S. Department of Veterans Affairs ("VA") in diagnosing and treating these challenging cases. To date, that suggestion has not been accepted.

AIG also relies on a Haydenville, Massachusetts company, Independent Claim Consultants Network, LLP ("ICCN"), and its President Lori Cohen, Ph.D., for expertise in identifying qualified professionals in connection with PTSD claims. ICCN's role is to locate an appropriate professional who can evaluate and recommend a treatment plan for the particular contractor's employee. ICCN's process, by which it vets these professionals, is described in documents accompanying this submission.

Dr. Griffith's Qualifications:

Among his many qualifications, Dr. Griffith is a licensed psychiatrist and pharmacologist who trained at the University of Tennessee (Memphis), and completed post-graduate training at VA hospitals in Atlanta, Georgia and Nashville, Tennessee. Dr. Griffith has been board-certified

in psychiatry throughout his long career. A copy of his Curriculum Vitae accompanies this submission.

Dr. Griffith has worked broadly in the field of psychiatry. He served as a psychiatrist in the U.S. Air Force, and has held a number of academic posts. Between 1984 and 2007, Dr. Griffith was a member of the faculty at the University of Texas (Houston) School of Medicine, after which time he retired to voluntary faculty status. Dr. Griffith has also authored and published extensively in medical literature; has performed research at the Addiction Research Center in Lexington, Kentucky; and has served in various posts related to alcoholism and substance abuse.

Significantly, DOL ALJs have touted Dr. Griffith's credentials and opinions in their decisions on several occasions involving claims of alleged of PTSD. As a board-certified and university-trained psychiatrist, Dr. Griffith is well qualified in the examination, evaluation and treatment of psychiatric conditions and disorders including, among others, PTSD. While Dr. Griffith does not limit his practice to PTSD, he does have expertise in the disorder from his professional education, training and decades of professional experience in psychiatry. Dr. Griffith has worked with patients with PTSD for the past 40 years. Dr. Griffith became experienced in handling such cases through his various affiliations with the VA health care system, roughly between 1965 and 1986. During this time, Dr. Griffith's patients were veterans of the Korean and Vietnam Wars, and routinely presented with symptoms of actual or claimed PTSD. Moreover, Dr. Griffith is qualified to both administer the MMPI-2 test and interpret its results, although in evaluating PTSD cases the MMPI-2 test is just one factor, combined with findings through record review and psychiatric review, which Dr. Griffith considers when conducting a comprehensive evaluation.

Dr. Griffith also has extensive trauma-related expertise from his four years of practice at M.D. Anderson Cancer Center in Houston, Texas. At M.D. Anderson, Dr. Griffith treated both cancer patients and their families, who typically presented with the characteristic range of sudden stressors that occur without a combat or violent origin. PTSD was a more or less daily consideration in his treatment of hundreds of patients and their families at M.D. Anderson.

Since 1957, Dr. Griffith has also performed forensic psychiatry examinations. He opened his private psychiatry practice in 1989, and now works in a *locum tenens* capacity for various mental health centers. Of note, Dr. Griffith has treated patients presenting with actual or claimed PTSD symptoms in his private practice.

Question 5: AIG notifies the DOL when a contractor cancels a DBA workers' compensation insurance policy. When a contractor cancels its DBA coverage, AIG sends to the DOL a DOL Form LS-570 evidencing the cancellation. This form is the same "yellow card" AIG sends to the DOL when a contractor binds DBA coverage with AIG.

Question 6: Similar to requirements under state workers' compensation laws, for DBA the employer/insured contractor must post a notice at its worksites providing information to its workers instructing what they should do in case of an injury or illness. *See* 20 C.F.R. §702.211. The notice required to be posted by employers is prescribed by the DOL, namely Form LS-241 entitled *Notice to Employees.*[2] This notice states the employer's name at the top, states that the employer is insured to provide workers' compensation benefits, and provides instructions under the "WHAT TO DO WHEN INJURED AT WORK" section.

While the obligation to disclose DBA insurance information to workers is the employer's, AIG has proactively undertaken substantial efforts to facilitate reporting. For example, through its normal course of communications AIG discusses with brokers, contractors and subcontractors the importance of reporting claims and how to report them. AIG has also provided on-site training for contractors and their subcontractors. In particular, AIG has conducted training on this subject in the Middle East, where subcontractors are used extensively. AIG has also conducted several educational seminars on DBA for the benefit of contractors. These seminars have been attended by DOL personnel, and in fact DOL staff has presented at the seminars.

AIG corresponds with foreign nationals in their native language whenever possible. AIG was the first carrier to translate DOL reporting forms and settlement documents into Arabic, Turkish (including the *Notice to Employees* Form LS-241 referenced above) and other languages in order to facilitate communication with local nationals in the Middle East. AIG shared these forms with the DOL, after which the DOL required other insurance carriers to translate their own forms into multiple languages. AIG personnel in Dubai and Istanbul are fluent in both spoken and written Arabic and Turkish, which provides AIG with the ability to communicate effectively with foreign nationals in the region. AIG personnel are versed in local dialects and speech accents to facilitate open communication with local populations.

AIG's efforts as outlined above facilitate claim reporting. Moreover, AIG makes sure to reach out to injured claimants leaving "the theater" to return home for rehabilitation and recovery in order to maintain an open dialogue throughout their treatment.

Question 7: AIG is aware of the *K.S. v. Service Employees, International Incorporated,* B.RB No. 08-0593 (March 13, 2009) decision and recognizes that it has the potential to affect average weekly wage ("AWW") determinations under 33 U.S.C. §910. The *K.S.* case is currently before the Benefits Review Board on a motion for reconsideration *en banc.* At this juncture it is premature to assess what precedential impact the case will ultimately have, especially since over the past few years ALJ decisions have trended consistently toward using the blended rate

[2] AIG previously produced this document marked as AIG0102.

approach. However, AIG is, and always has been, committed to following controlling precedent on AWW determinations and will address the impact of the *K.S.* case as appropriate.

Additionally, given that DBA claimants frequently worked both overseas and stateside during the year preceding their injury, in many instances the blended rate approach most effectively satisfies the purpose of the statute. As AIG has previously stated to the Subcommittee, Section 910 was drafted in contemplation of providing benefits for longshore and harbor workers who presumably worked in such capacity for many years - - essentially a static employment environment where job switching and sharp wage increases were the exception rather than the rule. It simply does not contemplate workers heading overseas in the same employment but for greatly enhanced wages, and was certainly not drafted in contemplation of thousands of contractors leaving stateside employment behind, heading to Iraq and Afghanistan to pursue higher wages in a new and different capacity, in a war zone, and with the intent to stay overseas for a relatively short time. The statute is simply not designed to calculate benefits for DBA claimants given the unique circumstances surrounding their employment, and for that reason the blended rate approach most often best represents the future earning capacity of the worker.

Question 8: AIG does not agree that it has "backtracked" on previous statements. As AIG has discussed with the Subcommittee, the nature of its computer systems does not enable AIG to garner precise quantitative, statistical or percentage metrics in answering certain Subcommittee questions. As such, in the face of Congressional requests for data, as opposed to inquiries from the news media, AIG has recently refined its characterization to be qualitative as instead of quantitative, without reference to specific percentages or other metrics. Regardless of whether described in terms of percentages or adjectives, however, AIG stands by its statements. AIG is committed to handling all claims professionally, ethically and fairly. As with all claims, AIG relies on its skilled staff, with oversight and supervision by its experienced management team to evaluate and resolve each claim individually on its own merits.

Question 9: Mr. Woodson sustained serious, life-changing injuries on October 28, 2004 while working overseas. AIG recognizes this fact, as evidenced by the significant benefits Mr. Woodson has deservedly received. To date, AIG has paid $792,647.46 on Mr. Woodson's behalf--$245,168.44 for indemnity benefits to compensate him for lost income due to his disabilities, and $547,479.02 for the medical treatment and care he needed as a result of his injuries. From the beginning, AIG recognized the severity of Mr. Woodson's injuries, and in addition to these indemnity and medical benefits had set aside indemnity reserves of $754,831.56 for future disability payments and $552,520.98 for future medical care. AIG has previously submitted a complete copy of Mr. Woodson's file to the Subcommittee.

AIG received Mr. Woodson's request to see an eye specialist and for new eyeglasses on April 16, 2009. That same day, AIG and the Nurse Case Manager authorized Mr. Woodson to obtain new eyeglasses. However, on April 24, 2009 the DFEC accepted Mr. Woodson's claim as

being reimbursable under the WHCA, and took over prospective handling of his claim. Once DFEC assumes responsibility for handling a war-risk hazard claim, AIG no longer has the authority to handle it. In Mr. Woodson's case, AIG made payments through April 23, 2009, the last day it had authority to make payments before DFEC took over the claim.

Significantly, the date of service as respects Mr. Woodson's eyeglasses was April 28, 2009, *after* DFEC took responsibility for his claim. Since that date, Mr. Woodson's eye doctor, Dr. Stiles, has billed AIG for three separate services for Mr. Woodson. AIG has submitted those bills to DFEC since AIG is no longer authorized to handle the claim or make any payments. Mr. Woodson's counsel was advised by letters dated May 18, 2009 and June 4, 2009 that DFEC had taken over handling of the claim. AIG also voluntarily contacted DFEC by telephone on June 24, 2009 and July 15, 2009 to determine the status of the bill payment for Mr. Woodson's eyeglasses, but those inquiries were not answered. On August 4, 2009 AIG again contacted DFEC, which advised that the bill for Mr. Woodson's eyeglasses was paid on July 9, 2009. DFEC further advised that the delay had been due to processing a new vendor in DFEC's payment system.

Question 10: AIG has previously provided a complete copy of Mr. Smith's file to the Subcommittee. Because this claim is very complex and involves multiple temporary and partial disability periods, as well as allegations of both psychological and physical injury, AIG would be pleased to meet personally with Subcommittee members and their staff in a non-public setting to explain the claims. AIG will also produce a copy of Mr. Smith's appeal brief in conjunction with this written submission as AIG14490.

Question 11: AIG would like to emphasize that the DOL "hearings" referred to in this question are, in fact, not formal proceedings adjudging disputes between the carrier and claimant, but are instead "informal conferences" among the parties and a DOL claims examiner. Most of these conferences are conducted telephonically. The parties do not generally submit position statements or any other written materials prior to these conferences. Rather, the parties simply have a conference call to discuss the claim with the examiner, and a non-binding recommendation follows.

Similar to countless non-binding mediations that take place everyday where mutual resolution is not achieved, AIG will on occasion not follow the non-binding recommendation made following an informal conference. AIG does not track or otherwise record data related to the instances in which it has or has not followed such a recommendation. AIG ultimately makes claims decisions following a complete accident and medical investigation and evaluation by trained DBA claim professionals.

Question 12: In his testimony before the Subcommittee, Mr. Schader made three recommendations for improving the DBA program for the benefit of the Government, claimants, employers and the American taxpayer. In addition to recommending greater inter-

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agency cooperation on the diagnosis, prognosis and treatment of PTSD, Mr. Schader made two recommendations for changes to current law: (1) rationalizing and simplifying the calculation of AWW, and (2) providing detailed, accurate status reports to claimants instead of the LS-207 controvertion notice. AIG respectfully refers the Subcommittee to Mr. Schader's testimony on these reforms during the June 18, 2009 hearing.

Of the two recommended legislative changes, however, AIG believes that addressing the AWW issue is the single most important reform that would enhance the ability of AIG and other insurers to provide fair and comprehensive benefits to claimants. In AIG's experience, this issue causes the greatest number of disputes and subsequent appeals, because this calculation constitutes the basis for determining disability benefits.

As the Subcommittee is aware, the DBA statute was created as an add-on to the 1941 Longshore & Harbor Workers Compensation Act, which was designed to meet the needs of longshore and harbor workers who typically pursue their claims in a stable environment, and who follow a predictable career progression. The current AWW statute is simply not suited to address the interests of thousands of employees who leave stateside employment for hazardous war zones at greatly enhanced salaries for a limited period of time before they return home. This situation has led to a great deal of inconsistency in the application of the law by ALJs. Clearer, more predictable rules for calculating a claimant's AWW would reduce the number of disputes and associated frictional costs, and would increase the satisfaction level for all parties, including claimants and their employers.

Please do not hesitate to contact us if you have additional questions, or if we can be of further help.

Sincerely,

Jeffrey L. Turner
Alexandra L. Chopin

cc: Honorable Jim Jordan, Ranking Member

Question 4)

CURRICULUM VITAE

Name:	John Dorland Griffith, M.D.
Present Title and Affiliation	Private Practice, 1989+ Clinical Assistant/Associate Professor of Psychiatry, The University of Texas School of Medicine at Houston, 1984 – Vol Fac. 2008.
Birth Date and Place:	March 22, 1931, Tennessee
Citizenship:	U.S.A.
Social Security:	[redacted]
Mailing Address:	9415 Denbury Way Houston, TX 77025 713-667-1133 or Cell:: 713-560-0418 Fax 713-661-5632
Licensure:	Texas, (F5924) Tennessee, (4328) Kentucky, (10837) AG 9172381
Education:	1949-50 Temple University, Philadelphia 1950-51 University of Tennessee (Engineering Physics) 1951-55 University of Tennessee School of Medicine (Memphis)
Postgraduate Training:	1955-56 Internship, Atlanta VA Hospital (Internal Medicine) 1956-59 Resident in Psychiatry, University of Tennessee (Memphis) 1970-71 Research and Education Associate (Clinical Pharmacology) Nashville VA Hospital, Dr. John Oates, Chief of Clinical Pharmacology, Vanderbilt University, Preceptor.

Military Service:	1959-61	Captain, USAF
Professional and Academic Appointments	1959-61	Chief, Psychiatry Section, USAF Hospital Keesler, Keesler AFB, MI
	1961-63	Director, Harriett Cohn Guidance Center Clarksville, TN
	1962-63	Clinical Instructor in Psychiatry, Departmet of Psychiatry, Vanderbilt University School of Medicine.
	1963-65	Director of Mental Health Planning, Department of Health, Oklahoma City, Oklahoma
	1963-65	Assistant Professor of Preventive Medicine and Public Health, Department of Preventive Medicine, University of Oklahoma Medical Center
	1963-65	Assistant Professor of Psychiatry, Department of Psychiatry, University of Oklahoma School of Medicine.
	1964-65	Research Associate, Speech and Hearing Center, University of Oklahoma.
	1965-70	Assistant Professor of Psychiatry, Department of Psychiatry, Vanderbilt University School of Medicine
	1968-70	Instructor, Department of Pharmacology Vanderbilt University School of Medicine
	1970-71	Associate Professor of Psychiatry, Department of Psychiatry, Vanderbilt University School of Medicine
	1970-71	Assistant Professor, Department of Pharmacology, Vanderbilt University School of Medicine
	1971-72	Associate Professor of Clinical Psychiatry, University of California, San Diego.
	1972-79	Associate Clinical Professor of Psychiatry,

University of Kentucky School of Medicine.

1972-79 Chief of the Stimulant Unit, National Institute on Drug Abuse, Addiction Research Center, Lexington, KY

1978-79 Special Assistant to the Director, National Institute on Drug Abuse, Rockville, MD.

1979-81 Chief, Psychiatry Inpatient Service, Texas Research Institute on the Mental Sciences (TRIMS), Houston, TX

1981-86 Medical Directory, Harris County Psychiatric Hospital, Houston, TX

1981-90 Associate Clinical Professor, Department of Psychiatry, Baylor College of Medicine, Houston, TX

1986-90 Associate Clinical Professor of Psychiatry, Department of Neuro-Oncology, M.D. The University of Texas System Cancer Center, M.D. Anderson Hospital and Tumor Institute at Houston

1984- Associate Clinical Professor, The University of Texas Medical School at Houston.

Public Service: Member, Governor's Committee on Alcoholism

Vice-President, Oklahoma City Council on Alcoholism

Board Member, Nashville Council on Alcoholism

Member and Acting Chairman, FDA Controlled Substances Advisory Committee

Member, Governor's Task Force on the Intellectually Handicapped and the Criminal Justice System, Austin

Produced two television programs on drugs and drug effects and one medical motion picture on suicide prevention.

Have assisted in the preparation of many newspaper and national magazine articles on drug psychotoxicity.

Society Memberships: (Past and Present)

American Association for the Advancement of Science

Fellow, American Psychiatric Association

Sigma Xi

New York Academy of Medicine

American Federation for Clinical Research

American Society for Clinical Pharmacology and Therapeutics

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ICCN's IME Evaluator Selection Process

One of the qualifications we consider is Board certification by one of the following Boards, although we do not only recommend Board certified evaluators:

American Board of Professional Neuropsychology
American Board of Professional Psychology
National Academy of Neuropsychology
American Academy of Clinical Neuropsychology
American Academy of Clinical Psychology
American Board of Forensic Psychology
American Board of Neurology and Psychiatry

We also locate potential evaluators by contacting hospitals, universities and colleges, forensic practices, and respected professionals whose services we have used.

Once a potential provider has been located, we conduct an interview to determine the evaluator's experience and expertise. We gather data about their experience in conducting disability, worker's compensation, and other types of forensic evaluations, experience working for plaintiff and defense attorneys, affiliation with universities, breadth of clinical practice, areas of specialty, and experience providing expert testimony.

Following the interview, we obtain data including curriculum vitae, malpractice coverage, licensing, and fee schedule. In addition, we require that the potential provider submit a redacted report for our internal review. Experienced ICCN evaluators review the sample reports for their comprehensiveness, thoughtfulness, even-handedness, and degree of complexity. We utilize only those evaluators whose work we find to be of the highest caliber.

Once the evaluator has been selected, we interview them to impress on them the need for a thorough assessment, recommending, when appropriate, the use of collateral interviews, thorough record review, comprehensive testing, and a detailed and lengthy clinical interview.

Selection of Expert Evaluators for PTSD Claims

It is unusual to find an expert forensic evaluator who specializes in only one psychiatric condition, such as PTSD. Rather, the expert evaluator is typically able to diagnose all psychiatric illnesses. There are many clinicians who specialize in the *treatment* of PTSD who are not highly skilled or trained in conducting independent medical evaluations. Expert forensic evaluators (psychologists, neuropsycholgists, or psychiatrists) are characteristically clinicians who by virtue of training and experience may assist a court or other fact-finder in arriving at a just or correct decision. They usually have specialized training in the assessment of all types of psychiatric illnesses and they are trained to consider occupational factors, psychosocial factors, and

motivational factors in arriving at conclusions about clinical status, etiology of the symptoms, and capacity for functioning occupationally, among other relevant questions.

Psychologists who conduct IMEs are usually very familiar with administering and interpreting the MMPI-2, as this is the most widely used personality measure in forensic settings in the United States. It is unusual for a psychiatrist evaluator, as opposed to a psychologist evaluator, to be trained in scoring and interpreting this measure, but it is not unusual for the psychiatrist to utilize this measure, have it independently interpreted through a computerized program, by a psychologist, or by a testing company, and then integrate the test findings with their own findings developed through record review and psychiatric interview.

Question 10)

IN THE UNITED STATES DEPARTMENT OF LABOR
OFFICE OF ADMINISTRATIVE LAW JUDGES

KEVIN SMITH-IDOL	§	
	§	**BRB NO.: 09-0283**
Claimant	§	
	§	**ALJ NO.: 2008-LDA-00258**
v.	§	
	§	**OWCP NO.: 02-135637**
SERVICE EMPLOYEES INTERNATIONAL, INC.,	§	
Employer,	§	
And	§	
INSURANCE COMPANY OF THE STATE OF PENNSYLVANIA	§	
Carrier.	§	

EMPLOYER/CARRIER'S PETITION FOR REVIEW

Service Employees International, Inc. ("Employer") and Insurance Company of the State of Pennsylvania c/o American International Underwriters ("Carrier"), petition the Benefits Review Board ("Board") to review the Decision and Order dated December 4, 2008, issued by the Honorable C. Richard Avery, Administrative Law Judge, and upon such review to reverse the ALJ's finding that Kevin Smith Idol ("Claimant") was not at maximum medical improvement and find that Claimant's work with Nuasis is suitable alternative employment. In addition, Employer/Carrier ask the Board to find them entitled to a credit for Claimant's earnings as a truck driver since his work related injury.

The ALJ's findings that Claimant has not reached Maximum Medical Improvement and disregard of Claimant's employment as a truck driver since returning to the United States fails the tests of validity of an ALJ's findings and conclusions; is contrary to the law; is unsupported

by the "substantial evidence in the record considered as a whole,"[1] and is arbitrary and irrational. To the extent that the finding of no MMI and no suitable alternative employment involved the ALJ's discretion, it constituted a gross abuse of such discretion.

Wherefore, upon review, the Board should vacate the ALJ's findings and conclusions that Claimant was not at MMI and that there was no suitable alternative employment on the grounds that it is not supported by the facts or law. The Board should further find Employer/Carrier entitled to a credit for all earnings Claimant received as a truck driver since returning to the United States.

BACKGROUND

On January 11, 2004, Kevin Smith-Idol ("Claimant") was hired to work for Employer as a heavy truck driver. (EX-1).[2] Claimant had been driving trucks since 1994, and had experience driving semi-trucks, end dumps, flatbeds, refers, and refrigerator trucks. (Tr. 16, 31). He drove the same types of trucks for Employer. (Tr. 31).

On April 8, 2004, Claimant suffered a gunshot wound to his left leg while driving in a convoy for Employer. (Tr. 7, 10). He suffered a Grade 3 open left femur fracture and has undergone an external fixation of the femur and two debridement procedures. (EX-12, pp. 22, 25, 29-30). On April 22, 2005, Claimant was discharged from physical therapy with the ability to occasionally lift 100 pounds, 50 pounds frequently, and 20 pounds constantly. (EX-12, p. 97). On April 26, 2005, Claimant completed a work conditioning program and was again released to return to any work that did not require frequent climbing or excessive lifting of 100 pounds. (EX-12, p. 299).

On May 4, 2005, Dr. Cooke opined that Claimant plateaued with work conditioning and

[1] Longshore and Harbor Workers' Compensation Act 21(b)(3).
[2] Employer submitted exhibits before the Administrative Law Judge, which are referred to herein as EX-__.

released him to return to work without restrictions. Claimant was also discharged from further treatment. (EX-12, pp. 294, 301).

On May 10, 2005, Claimant began treating with a neuropsychologist, Dr. Brinkman and was diagnosed with chronic PTSD. (EX-12, pp. 303-304).

On September 2, 2005, Claimant underwent an independent medical evaluation with Dr. Singleton, who opined that Claimant had reached maximum medical improvement and would only need maintenance with medication. (EX-12, pp. 322-328).

Claimant was voluntarily paid temporary total disability benefits and medical benefits from April 9, 2004 through September 2, 2005. (EX-7; EX-9). On September 3, 2005, Employer/Carrier began paying Claimant a scheduled award for a permanent partial disability benefits as a scheduled award based on a 26 percent permanent impairment rating to his leg. (EX-9). The percentage of impairment was determined by Dr. Singleton and affirmed by Dr. Cooke. (EX-12, pp. 61, 338-340).

On October 3, 2005, Dr. Brinkman terminated treatment with Claimant and told him to "get on with his life." (EX-12, p. 341). On November 8, 2005, Dr. Brinkman opined Claimant was at MMI and had no problems with the cognitive aspects of driving. (EX-12, pp. 348-349).

In February 2008, Claimant returned to work as a truck driver for Nuasis Power Equipment Company ("Nuasis"), driving a semi truck with a lowboy trailer and earning $12 per hour. (Tr. 28-29, 31). Claimant also averaged about two hours of overtime per week at $18 per hour. (Tr. 31-32). He testified that he delivers equipment to customers and works five days per week. (Tr. 29-31). Claimant admitted that as of July 30, 2008, he had only taken three unpaid vacations to go to the formal hearing and had otherwise worked continuously since February 2008. (Tr. 29-30). Claimant was driving the same types of trucks he drove prior to and with

Employer. (Tr. 29, 31). As of the formal hearing, Claimant still worked for Nuasis. (Tr. 30).

Claimant was never disciplined by his new employer and his ability to drive a semi truck had never been questioned. (Tr. 39-40). Claimant even told Nuasis that he was shot in his leg and had a disability that could limit his abilities. (Tr. 39-40). Claimant advised Nuasis that he may not be able to do the work non-stop and may have to take frequent breaks. (Tr. 39). Claimant also told his Nuasis that he would have to stay off his leg as much as possible. (Tr. 39). Claimant was hired despite these disclosures and has been provided accommodations. (Tr. 40).

On March 5, 2008, Claimant returned to Dr. Cooke for a follow up with his leg for the first time since May 2005. Claimant had good range of motion and the femur appeared to be well healed. Dr. Cooke completed a Texas Workers' Compensation Work Status Report and opined that Claimant could return to his usual employment without restrictions. (EX-12, pp. 405, 408).

On March 12, 2008, Dr. Brinkman acknowledged that Claimant had returned to work as a heavy equipment driver and noted that it was an example of Claimant trying to overcome his symptoms. (EX-12, p. 409). Dr. Brinkman did not opine that Claimant could not do the work and did not place any work restrictions upon Claimant at that time.

Claimant admitted that he drove himself from Abilene, Texas to Houston, Texas – 409 miles – for the formal hearing, without problems. (Tr. 37).

On July 30, 2008, the parties attended a formal hearing.

PROCEDURAL HISTORY

The issues at formal hearing were causation regarding his claim for PTSD, Nature and Extent of Disability, and Section 7 medical benefits. Claimant argued that as a result of the

gunshot wound, he suffered from continuing PTSD and his benefits should have continued after completion of his scheduled award. As such, Claimant sought continued compensation benefits based on his claim for PTSD and continued medical care for his leg and psychological complaints.

Employer/Carrier countered that Claimant had been voluntarily paid TTD benefits until he was placed at MMI after a series of functional capacity evaluations and work hardening programs, as well as an assignment of a 26 percent permanent impairment to his left leg. Claimant then voluntarily paid Claimant based on a scheduled award to Claimant's leg for an additional 112 weeks of compensation. Employer/Carrier argued that Claimant could return to his usual employment as a truck driver and therefore suffered no continuing disability. Alternatively, Employer/Carrier argued that Claimant's work as a truck driver in the United States was suitable alternative employment and Claimant had a post injury earning capacity of at least $516 per week.

The Court ultimately determined that despite Claimant's treating physician's opinions that Claimant reached maximum medical improvement as to his leg by May 6, 2005; and as to his psychological problems by October 3, 2005, Claimant was not at MMI as to either conditions.

In addition, the Court determined that despite Claimant's own testimony that he was capable of performing his job duties at Nuasis and that he informed his new employer of his gunshot injury and limitations, that Employer/Carrier had not established suitable alternative employment.

Finally, the Court did not take into account the fact that Claimant had been working for Nuasis since February 2008, earning a minimum of $516 per week, and failed to find that

Claimant was at least partially disabled from February 2008 until he stops working for Nuasis[3] and that Employer/Carrier were entitled to a credit against Claimant's indemnity benefits for those post injury earnings.

STANDARD OF REVIEW

The United States Fifth Circuit Court of Appeals has succinctly set forth the scope of review for the Benefits Review Board:

> The Board does not have the authority to engage in a *de novo* review of the evidence or to substitute its views for those of Judge Romero. The findings of the ALJ must be accepted unless they are not supported by substantial evidence in the record considered as a whole or unless they are irrational. *Mijangos v. Avondale Shipyards, Inc.*, 948 F.2d 941, 944 (5th Cir. 1991).

"Substantial evidence" means "more than a mere scintilla," and is evidence that a "reasonable mind might accept as adequate to support a conclusion." *Richardson v. Perales*, 402 U.S. 389, 401 (1971).

QUESTION PRESENTED

Whether the ALJ's Decision and Order findings that Claimant was not at MMI, that Claimant's current work was not suitable alternative employment, and the absence of a finding that Employer/Carrier were entitled to a credit based on Claimant's earnings with his new employer, were in error, unsupported by substantial evidence on the record as a whole, and contrary to law.

[3] As of the formal hearing, Claimant was still working for Nuasis.

ARGUMENT

A. The ALJ erred in finding that Claimant had not reached Maximum Medical Improvement.

Employer/Carrier maintain that whether Claimant had reached maximum medical improvement was never an issue before the Court. In addition, the record fully supports a finding that Claimant has been at MMI since at least May 2005 as to his left leg, and has been at MMI regarding his psychological issues since October 3, 2005. (EX-12, pp. 301-302, 327, 339, 341, 349). These releases were given by Claimant's own treating doctors after he completed work hardening and conditioning programs and never changed despite Claimant receiving additional medical care. Nevertheless, the ALJ wrongfully ignored the opinions of the treating physicians and found that Claimant was not at maximum medical improvement.

Disability is an economic concept based upon a medical foundation distinguished by either the nature (permanent or temporary) or the extent (total or partial). A permanent disability is one which has continued for a lengthy period and is of lasting or indefinite duration, as distinguished by one in which recovery merely awaits a normal healing period. *Watson v. Gulf Stevedore Corp.*, 400 F.2d 649 (5th Cir. 1968); *Seidel v. General Dynamics Corp.*, 22 BRBS 403, 407 (1989); *Stevens v. Lockeed Shipbuilding Co.*, 22 BRBS 155, 157 (1969). A claimant's disability is permanent in nature if he has any residual disability after reaching maximum medical improvement. *Trask v. Lockheed Shipbuilding Construction Co.*, 17 BRBS 56, 60 (1980).

The date of maximum medical improvement is a question of fact based upon the medical evidence of record. *Ballesteros v. Willamette Western Corp.*, 20 BRBS 184, 186 (1988); *Williams v. General Dynamics Corp.*, 10 BRBS 915 (1979). An employee reaches maximum medical improvement when his condition becomes stabilized. *Cherry v. Newport News*

Shipbuilding & Dry Dock Co., 8 BRBS 857 (1978); *Thompson v. Quinton Enterprises, Ltd.*, 14 BRBS 395, 401 (1981). In addition, an irreversible condition is permanent per se. *Drake v. General Dynamics Corp.*, 11 BRBS 288, 290 (1979). A disability is also considered permanent if the impairment has continued for a lengthy period and appears to be of an indefinite duration rather than a disability that would recover after a normal hearing period. *Crum v. General Adjustment Bureau*, 738 F.2d 474, 480 (D.C. Cir. 1984); *Care v. Washington Metro Area Transit Auth.*, 21 BRBS 248, 251 (1988) (permanency is the date the employee stops receiving treatment with a view toward improvement of his condition).

A condition is not prevented from being called permanent just because a doctor notes that future surgery is necessary. *Worthington v. Newport News Shipbuilding & Dry Dock Co.*, 18 BRBS 200, 202 (1986). If a doctor opines that a condition will progress and require future surgery, but also places a permanent disability rating upon a claimant, then the record supports a finding that maximum medical improvement has been reached, if the disability will be lengthy, indefinite in duration, and lack a normal healing period. *Morales v. General Dynamics Corp.*, 16 BRBS 293, 296 (1984), *aff'd in pert. part sub nom. Director, OWCP v. General Dynamics Corp.*, 769 F.2d 66 (2d Cir. 1985).

The very nature of Claimant's injury, the gunshot wound to his leg, has caused a severe injury to Claimant's leg that will never go away. Claimant had hardware placed in his leg from his knee to his thigh. The injury will continue to cause scar tissue to develop and may necessitate future surgeries. However, the potential for necessary future treatment is not enough to find a condition no longer permanent in nature. Claimant's leg will never improve beyond its condition in May 2005, when Claimant's treating physician opined that he had reached maximum medical improvement. The necessity for additional medical care is to maintain

Claimant's current functional capacity with his leg and to prevent it from worsening, not to assist it in getting better. As such, Employer/Carrier respectfully request that the Board reverse the ALJ's finding that Claimant was not at MMI as to his left leg and enter a finding that Claimant reached MMI as of May 4, 2005, as opined by Dr. Cooke.

In addition, there is no evidence supporting a finding that Claimant was not at MMI as to his claim for PTSD. Claimant's treating psychologist, Dr. Brinkman, opined that Claimant reached MMI on October 3, 2005. There is no evidence to support a contrary finding. Again, while Claimant may necessitate continued psychological care, that alone does not justify a finding that Claimant is no longer at MMI. Claimant's treating physician has opined otherwise and the record supports a finding of MMI. On October 3, 2005, Dr. Brinkman advised Claimant to "get on with his life" and terminated further medical care. (EX-12, p. 341). In addition, Dr. Brinkman opined that Claimant had no cognitive problems that would affect his ability to drive and Claimant was only mildly to moderately psychologically impaired. (EX-12, pp. 348-349). In May 2006, Claimant was noted as doing well on his psychiatric medication. (EX-12, p. 356). While Claimant may need medication management and ongoing counseling, his treating physicians believed he was at MMI in October 2005. In addition, it has been 5 years since the originating incident and Claimant's condition has stabilized.

The facts remain that Claimant's doctors have released Claimant at maximum medical improvement as to his left leg injury and his psychological complaints. As such, the ALJ's finding that Claimant was not at maximum medical improvement is unsupported by the medical evidence and should be reversed as in error and an abuse of discretion.

B. The ALJ erred in finding that Claimant's current employment was not suitable alternative employment

Employer maintain that the Claimant's return to work as a truck driver in the United States is proof that he is capable of returning to his usual employment as a truck driver and he therefore suffers no continuing disability. Alternatively, Employer/Carrier maintain that Claimant's return to work for Nuasis establishes suitable alternative employment and therefore if he suffers from a continuing economic disability as a result of his work injury, then his condition is partial in nature as he has a post injury earning capacity of $516 per week.

Once a Claimant establishes that he can no longer perform his usual employment due to a job related injury, the disability becomes total in nature. *New Orleans (Gulfwide) Stevedores v. Turner*, 661 F.2d 1031, 1038 (5th Cir. 1981); *P&M Crane Co. v. Hayes*, 930 F.2d 424, 429-430 (5th Cir. 1991); *SGS Control Serv. v. Director, OWCP*, 86 F.3d 438, 444 (5th Cir. 1996); *Walker v. Sun Shipbuilding & Dry Dock Co.*, 19 BRBS 171, 172 (1986). A total disability will become partial on the earliest date that suitable alternative employment can be established. *Palombo v. Director, OWCP*, 937 F.2d 70, 73 (D.C. Cir. 1991); *Rinaldi v. General Dynamics Corp.*, 25 BRBS 128, 131 (1991). A Claimant's post injury employment may constitute evidence of alternative suitable employment even when the Employer has failed to introduce direct evidence of suitable employment opportunities in the claimant's geographic area. *Sledge v. Sealand Terminal, Inc.*, 14 BRBS 1-334, 1-337 (1981).

Employer/Carrier maintain that Claimant was at most partially disabled by virtue of his actual wage earning capacity with Nuasis and that the Administrative Law Judge erred in finding that Claimant's actual employment was not a suitable alternative employment opportunity. Claimant testified that he informed his new employer that he was shot in the leg and that he had limitations that could affect his ability to perform his job duties. In addition, Claimant also

advised them that he may not be able to do the work non-stop, would have to take breaks, and would have to stay off his left leg as much as possible. (Tr. 39). Despite all these limitations, Claimant was hired by Nuasis to work as a truck driver.

Since Claimant started working for Nuasis, he has never been disciplined and has never missed even one day of work due to his injury to his leg or psychological condition. The only time Claimant took time off from Nuasis was to attend the July 30, 2008 formal hearing. As such, Claimant worked for Nuasis for at least five months prior to the formal hearing without any problems and without having to take anytime off due to pain or medical care. Claimant admits that he is capable of working at least eight hour days, five days per week, and even averages about 2 hours per week in overtime.

Based on the above, Employer/Carrier maintain that the ALJ erred in finding that Claimant's current work with Nuasis was not suitable alternative employment. As such, Employer/Carrier respectfully request that the Board vacate the ALJ's finding of total disability and enter a finding that Claimant is partially disabled with a post injury earning capacity of $516 per week.

C. Employer/Carrier are entitled to a credit for all earnings Claimant earned with Nuasis since February 2008.

Regardless of the ALJ's ultimate Decision and Order regarding Nature and Extent of Disability, the fact remains that Claimant began working for Nuasis in February 2008, and has been earning about $516 per week since that time. Even if Claimant is found entitled to total disability benefits during that period, Employer/Carrier maintain that they are entitled to a credit for any earnings Claimant received from February 2008, until whenever time Claimant stopped working for Nuasis. As of the formal hearing, Claimant continued to work for Nuasis. As such, Employer/Carrier would be entitled to a credit of $516 per week from February 2008, up through

the July 30, 2008 formal hearing and continuing until, or when, Claimant stopped working. Employer/Carrier maintain that the ALJ erred by only allowing a credit for compensation benefits paid and for not accounting for the post injury earnings Claimant's received.

CONCLUSION

For the foregoing reasons, Employer/Carrier respectfully request that the Board vacate the ALJ's finding that Claimant had not reached maximum medical improvement and that his current job did not constitute suitable alternative employment. Alternatively, should the Board affirm the ALJ's findings, the Board should find Employer/Carrier entitled to a credit for all post injury earnings since February 2008, up to whenever, or until Claimant stops working for Nuasis.

Respectfully submitted,

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ATTORNEYS FOR SERVICE EMPLOYEES INTERNATIONAL AND INSURANCE COMPANY OF THE STATE OF PENNSYLVANIA

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing document has been forwarded this 21st day of April, 2009, via either facsimile, certified mail/return receipt requested, hand-delivery, express mail and/or regular U. S. Mail to:

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Bradley Soshea
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Limor Ben-Maier